No. 91-470

In The

Supreme Court of the United States

October Term, 1990

In the Matter of
DANIEL R. HODGE, M.D.,
Petitioner,

vs.

New York State Department of Education, New York State Board of Regents, Thomas Sobol, Emlyn I. Griffith, Henry A. Fernandez, Jane M. Bolin, Patrick J. Picariello, Martin C. Barell, Carlos R. Carballada, Willard A. Genrich, Jorge L. Batista, Laura Bradley Chodos, Louise P. Matteoni, J. Edward Meyer, Floyd S. Linton, Mimi Levin Lieber, Shirley C. Brown, Norma Gluck, James W. McCabe Sr., Adelaide L. Sanford, Walter Cooper, Charles J. Adams, Daniel W. Szetela, Ann R. Eldridge, Christopher Lefkarites, Esq., Andrew A. Tolkof, Esq., Howard J. Goodman, Esq., Diane G. Maupin Esq., Lance R. Plunkett, Esq.,
Respondents.

ON PETITION FOR WRIT OF CERTIORARI TO THE STATE OF NEW YORK COURT OF APPEALS

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September 14, 1991

QUESTIONS PRESENTED

1. Whether the State of New York court of appeals denied Petitioner, constitutionally-protected, **Scientific Substantive Due Process** by not granting Petitioner's repeated motions to form an **independent committee of medical experts** in the fields of infectious diseases, immunology, cardiology, pulmonary medicine and endocrinology to apply the **best evidence medical standards** in critically analyzing Petitioner's scientific defenses to fabricated charges and pretended offenses of professional medical misconduct?

2. Whether Petitioner's due-process-required **"opportunity to be heard,"** actually and constructively vanished before an ill-educated, so-called hearing committee which fabricated medical data and concocted meaningless clinical circumstances, found Petitioner guilty of specifications with which Petitioner was not even charged, and never used a single textbook, journal or periodical to support its conclusions and even then, considered the New York State prosecutor's just as ill-educated, so-called medical expert, as **"our own medical expert?"**

3. Whether the State of New York court of appeals, the appellate division, third department justices, the New York State commissioner of education, the New York State board of regents and the regents review committee are just as guilty as the reviewers below them of civil misconduct under 28 U.S.C. 1343 and criminal misconduct under 18 U.S.C. 241-242 for **scientific fraud** perpetrated in a conspiracy, under color of law, even from behind the bench?

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ON PETITION FOR WRIT OF CERTIORARI TO THE STATE OF NEW YORK COURT OF APPEALS

Petitioner prays that a writ of certiorari be issued to review the July 9, 1991 dismissal (AP 1)[1] by the State of New York, court of appeals of Petitioner's appeal as of right, purportedly upon the ground that no substantial constitutional question is directly involved, and the denial of Petitioner's motion to appeal by permission, an Article 78 proceeding to review and annul the order of the New York State commissioner of education.

OPINIONS BELOW

The Opinion of the appellate division, third department

[1] "AP" denotes the appendix attached to this Petition.

and the Judgment affirming the order of the New York State commissioner of education, are reprinted in the Appendix to this Petition (AP 2-7), infra. The order of the New York State commissioner of education is reprinted at (AP 9-12); the report of the regents review committee is reprinted at (AP 13-20); exhibit A, attached thereto, the statement of charges, is reprinted at (AP 21-27); exhibit B, attached thereto, the report of the hearing committee, is reprinted at (AP 28-57); exhibit C, attached thereto, the recommendation of the commissioner of health, is reprinted at (AP 58-59); exhibit D, attached thereto, the terms of probation of the regents review committee, is reprinted at (AP 60-62); the notice of investigative proceeding is reprinted at (AP 63-64).

JURISDICTION

On July 9, 1991, on the sua sponte motion of the State of New York court of appeals, petitioner's appeal as of right was dismissed and petitioner's motion for leave to appeal was denied. This Court has jurisdiction to review those Judgments under 28 U.S.C. 1257 (3) and Rule 10.1 (c) and 13 of this Court.

CONSTITUTIONAL PROVISIONS, STATUTES AND RULES INVOLVED

U.S. Constitution, Amendment XIV

Section 1. ... No state shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States, nor shall any state deprive any person of life, liberty or property without due process of law, nor deny to any person within its jurisdiction the equal protection of the laws. Others continued at (AP 65-68).

STATEMENT OF THE CASE

On April 12, 1988 Petitioner, Daniel R. Hodge, M.D., a Black citizen, was served with a **statement of charges,** (AP 21-27) having twenty (20) synthesized charges of alleged medical misconduct, brought on by the New York State department of health, office of professional medical conduct (OPMC), a

disciplinary subdivision of the executive branch of New York State government. Petitioner was simultaneously served with a **notice of investigative proceeding,** (AP 63-64) which had as its sole objective the psychiatric evaluation of Petitioner Daniel R. Hodge, M.D., because Petitioner had allegedly given the prosecutor, associate counsel Paul R. White, Esq., and the hearing committee, **"reason to believe that you may be impaired by mental disability and therefore, whether it [the hearing committee] should issue an order directing that you submit to a complete psychiatric examination,"** for making caricatures, writing poems and vignettes, ridiculing the white racist, **"Northern Liberal"** bureaucracies, particularly, about the liability under 42 U.S.C. 1985, 1986 for conspiratorial assent in the preparation of fabricated medical misconduct charges, of erstwhile New York State's health commissioner David Axelrod and governor Mario M. Cuomo, comparing Mario M. Cuomo to Alabama's notorious governor George Corley Wallace, who stood **"in the schoolhouse door,"** to bodily prevent Black students from entering the University of Alabama, on June 11, 1963.

In a mock affidavit, reproduced among other places, in the appendix of ***Hodge vs. Kelly et al.,*** cert. denied, 490 U.S. 1081 (1989), Petitioner broadcasted that governor Mario M. Cuomo, constructively and actually accomplished, even in 1986 - the very same feat as did George C. Wallace - of keeping Petitioner, under maliciously imposed economic duress, from being able to **physically attend classes** at the State University of New York at Buffalo law school, in that governor, Mario M. Cuomo, readily acceded to - in fact, promoted - the racist conduct of Attica Prison officials, directly under the governor's control, allowing them to convert a set of **three fungible, routine weekly medical clinics,** regularly scheduled and held Monday through Friday from 9:00-11:00 AM, 1:00-3:00 PM and 7:00-9:00 PM, into an instantly fabricated, never-before-never-since seen, 10:00 AM-4:00 PM, clinic monstrosity, having no rational or any other kind of relationship whatsoever, to a legitimate health care objective, at Attica Prison, but which was merely concocted, devised and ensconced, to maliciously preclude **law school**

classroom attendance by this Petitioner, in the middle of the second semester, on that vulnerable and now **"venerable"** Valentine's Day, February 14, 1986. The New York State attorney general, Robert Abrams - now an announced prospective democratic candidate for the Unites States Senate - so successfully defended that atrocious-and reprehensibly racist state-employer conduct as being a **"management prerogative,"** all the way up the federal judicial tiers of ambition and review to this Court, at which level the light-years-apart, super-liberal left and the ultra-conservative right, imperceptibly merge homogeneously into a uniform white-is-right, modern milk. The problem has not gone away, even after five years of tribulations and torturings of this Petitioner and the struggle for freedom and justice, most surely shall remain ablaze all **"through the perilous fight, O'er the ramparts,"** of our enduring Constitution, until justice, in our scientific democracy, shall have indeed been had. This Petitioner has come too far by **faith** to turn around now.

On March 2, 1987, Petitioner made a well-informed, clinical judgment not to proceed, in an inchoate attempt, with what was - to an independent professional - clearly and obviously, a futile and potentially perilous **"rescue mission"** of resuscitating an inmate { a Patient C, in the **statement of charges** (AP 22)} who suffered a cardiac dysrhythmia and disorder - including several possible combinations and permutations of rhythms, either ventricular fibrillation (a uselessly quivering heart almost always fatal) or tachycardia (a very rapid heart beat) or bradycardia (a very slow heart beat) or asystole (no beat) - for which the prison medical health care staff was neither trained, equipped nor protected - refusing to even follow Petitioner's reasonable command that they, at the very least, wear gloves, let alone, masks and goggles - as are required by **Center for Disease (CDC)** guidelines for **Human Immunodeficiency Virus (HIV)** infection control, not to mention the dictates of plain old common sense, in a prison system where 70% of inmate deaths are from AIDS. Prison authorities seized upon that opportunity to place Petitioner on administrative leave, with pay, on March 16, 1987 - **"pending an investigation of the inmates death."** It was really in retaliation for their having been sued for blatant racial

discrimination by the Petitioner, in ***Hodge vs. Kelly et al.***

The New York State department of health's, office of professional medical conduct (OPMC), was **"called in"** to **"investigate"** the alleged **"medical misconduct"** in a conspiracy orchestrated in concert with the New York State departments of correctional services, department of law and several hospitals, namely, Lake Shore Hospital, in Silver Creek, N.Y., Tri-County Memorial Hospital, in Gowanda, N.Y., and Columbus Hospital of Buffalo, N.Y. The conductor of the racist rhapsody, in multiple movements and variations - having only one theme of, **"Get ridda Hodge,"** - was the irascible, **late Paul R. White, Esq.,**[2] who made rounds at several hospitals where Petitioner, Daniel Hodge, worked as a locum tenens Emergency Room physician and then collected a multitude of **"other"** alleged acts of **"medical misconduct,"** which have absolutely no medical merit, and were based, among other things, on the testimony of so-called **"fact witnesses,"** six of whom were white - not so bright - nurses, and three patients who, although they received appropriate medical care, nevertheless, were displeased for various reasons which had little to do with medical science or the legitimate doctor-patient relationship.

The so-called professional review procedure had all the makings and markings of a kangaroo court, with hearsay-upon-

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[2] New York State department of health, associate counsel for the office of professional medical conduct (OPMC) was killed in an auto accident on August 2, 1990. The late Mr. White had prepared, allegedly pursuant to **Public Health Law, Section 230, Education Law, Section 6509 and the State Administrative Procedure Act, Article 3,** a so-called **statement of charges** containing the twenty (20) alleged cases of **"medical misconduct, incompetence, negligence"** against the Petitioner, Daniel Hodge, and prosecuted the case from May 26, 1988 until May 12, 1989.

The late Mr. Paul R. White, Esq., ***criminally altered or destroyed*** portions of three medical charts in an attempt to support his case against this Petitioner. The documentary evidence against Mr. White is irrefutable and New York State's defense depends on an event - **the removal of only the Emergency Room chart, consisting of a single page, from a collection of 70 other pages in a Patient's (L) medical record** - with ***probabilistic odds*** that are incredulously unlikely (1.42% chance) to have spontaneously occurred, during the chain of custody, either in the copying process or record certification procedure or mailing.

hearsay **"evidence"** presented by malicious and ill-educated nurses, often taking matters completely out of medically valid context, to further the aims of the conspiracy, those utterances being considered, nevertheless, as scientific fact. The **statement of charges** incessantly made heavy use of the term **"failed to,"** in a barrage of professional assaults, such as, **"Respondent [meaning this Petitioner] failed to order this test, and failed to do a complete physical, or failed to look into the ear with an otoscope,"** when, in fact, those tabloid phrases really should be taken to mean that Petitioner, by a **well informed clinical judgment,** and from **seasoned empirical experience,** simply **"elected not to do x, y, or z,"** because categorically those tests or maneuvers would either add nothing of a clinically valid dimension to the situation, whether for diagnostic or treatment **purposes,**[3] were either futile or dangerous or would be outright

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[3] Any physician can detect an obvious fracture, but it is those **hairline varieties** which became fodder for the hearing committee, particularly for this myopic Petitioner, who for that reason, among other things, chose not to be a radiologist (X-ray specialist: Dr. Panaro, Petitioner's expert witness, is a radiologist, but Dr. Luria, the State's expert witness, is not). Even while being forced to admit that a non-radiologist (non-X-ray specialist) as the Petitioner, has **no professional duty** to make a **definitive** radiological diagnosis, but only a **preliminary** (and patients are routinely so informed that such readings are not official and can be altered by the only physicians board certified to officially interpret X-rays: Radiologists.), the members of the hearing committee, nevertheless, extended such a duty to the Petitioner when it suited their malicious aims.

The hearing committee, for example, concluded (AP 46) that, **"While Respondent did not interpret the x-rays of Patient D's right ankle to indicate an avulsion [hairline] fracture of the tip of the distal fibula, testimony was offered by Dr. Victor Panaro (Tr., Page 1511, lines 18-24) and Dr. Milton Luria (Tr., Page 499) that fractures of this type are frequently overlooked by a non-radiologist. Therefore, this charge is not sustained . . . .While Respondent did not interpret the x-rays of Patient E to indicate a [hairline] fracture of the right proximal tibia, testimony was offered by Dr. Victor Panaro (Tr., Page 1533, line 15-17) that fractures of this type are frequently overlooked by a non-radiologist and that Respondent cannot be held to the same standards as a radiologist. Therefore, this charge is not sustained. However, it should be noted that Dr. Hodge's knowledge of a clinical presentation of fractures is inadequate."** (AP 46) That professional assault is nonsense - it sounds pedantic and preachy to a neophyte and the lay public - but a severely painful and visibly damaged site on the surface of the skin may have no underlying fracture - even hairline - whereas a less painful undamaged skin surface may reveal an underlying

(continued...)

malpractice. A physician appropriately trained in the fields of infectious diseases, immunology, cardiology, pulmonary medicine and endocrinology (hormones) and various other specialties would readily - for those reasons - appreciate the fact that the proceeding was indeed a **"Mickey Mouse, Donald Duck,"** affair, being perpetrated for some purpose other than the genuine scientifically supportable and clinically valid review of professional medical conduct.

In its so-called **"report of the hearing committee,"** the hearing committee, consisting of a lay person and two physicians - an internist and a surgeon - made a total mockery of medicine and the peer review process. The hearing committee conjured up oxymoronic terms such as **"infected cyst,"** (AP 40) when a cyst by definition is sterile. The term **"witnessed cardiac arrest,"** (AP 45) ill-educatedly was interpreted and taken by the so-called hearing committee to mean **merely being in the same room with a patient, at the moment of "suspected" cardiac standstill,** when by definition - according to the **American Heart Association's textbook of Advanced Cardiac Life Support** - it specifically means that a patient must be **actually hooked up** to a cardiac monitor, at the instant of cardiac standstill. **Then and only then,** is the **"precordial thump,"** recommended to be used on a patient. (AP 34) Said the malicious and ill-educated hearing committee,

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[3](...continued)
hairline or even displaced fracture.

When Petitioner for practical reasons at 1:40 a.m., in the morning deferred taking an X-ray, rather than calling in an X-ray technician, because the trauma and physical signs of damage were relatively minor and where **preliminary treatment,** in the context of emergency medicine, would be no different whether or not there was a minor fracture - which turned out to be a **hairline fracture** anyway, as are all the fractures in the statement of charges - the hearing committee members went into their malicious and ill-educated war path and **"failed to perform and failed to order"** high gear, **"Respondent failed to perform an adequate physical examination and evaluation of the swelling to the knuckle of the last finger on the right hand of Patient F and failed to order an x-ray examination (Tr., Pages 515-516; Department's Exhibit 25; Tr., Page 1010). Respondent was negligent in his care of Patient F in that he failed to order an x-ray examination. Therefore, this charge is sustained."** The Petitioner simply elected not to do X-rays at 1:40 a.m., in the morning. It had nothing whatsoever to do with negligence or competency since the preliminary treatment was the same.

"Respondent did not attempt a precordial thump on Patient C's chest." That statement is absolute, pseudo-scientific fraud. There was no cardiac monitor or defibrillator in Attica Prison, the alleged site where the Patient C statement of charges emanates.

And even more atrociously, the hearing committee considered itself as being an arm of the New York State prosecutors, instead of a neutral panel, and fully adopted the very language, context and essence of the prosecutors brief - including mimicking legal case law support, by falsely using arbitration as having preclusive res judicata affects (AP 16,17,44). The hearing committee, although pretending to understand, knew nothing about law. But even more appallingly, the hearing committee considered the New York State medical expert witness as being, **"our own expert witness."**

The overzealous so-called neutral hearing committee, using its warped system of accounting, **"unanimously"** found the Petitioner guilty of negligence - i.e., in the category of the **"first specification"** of charges - in the case of Patient A, B (AP 32) and Q (AP 42), when Petitioner was not even charged with negligence, in those cases. Instead, in cases A and B, the alleged professional misconduct conjured-up, under color of law, and in a conspiracy with Lake Shore Hospital defendants, Foster, Feldman and Cardamone, by the New York State prosecutor was **"revealing personally identifiable information obtained in a professional capacity without prior consent of the patient,"** allegedly within the meaning of 8 NYCRR 29.1 (a)(8), a rule of the education department. In the case of Patient Q, the charge was - not negligence - but allegedly that Petitioner, **"verbally harassed, abused or intimidated a patient,"** within the meaning of 8 NYCRR 29.2 (a)(2).

Neither sets of charges amount to much more than a **Mickey Mouse/Donald Duck** quackery, charade and chicanery, representing a maliciously contrived, overreaching, literal application by the late Paul R. White, Esq., New York State department of health prosecutor, of grossly unreliable, hearsay-upon-hearsay **"facts"** to some totally out of context situations, using a rule, under color of law and in a conspiracy, designed merely to compromise Petitioner's medical license in retaliation

for Petitioner having sued for racial discrimination in ***Hodge vs. Lake Shore Hospital et al.***, and in ***Hodge vs. Kelly et al.***

Actually, Patient B, is the **"amputation case,"** in ***Hodge vs. Lake Shore Hospital et al.***, brought before this Court on August 10. 1991, where a 15 year old white male patient, involved in a dirt bike accident, sustained an almost complete severance of the tip of his left great toe, which was merely hanging by a thin layer of skin and which Petitioner - without the benefits of micro-surgical techniques - re-attached any way, ingeniously using the toe prints as **"high tech,"** landmarks, even after being advised by the surgeon, Dr. Velez, in a telephone consultation, to complete the amputation and make a stump. Had Petitioner done so, then there would have been some other **Mickey Mouse** charge to be sure, but not this Patient B case. Miraculously, the following day it was apparent that the toe survived, although classically such replantations rarely regain vascularity (blood circulation) or viability, let alone functionality, as the medical literature **confirms.**[4] When the Lake Shore Hospital administrator, James B. Foster, C.E.O, and two physicians, Joseph G. Cardamone, M.D., and Lynn Feldman, D.O., maliciously removed the Petitioner from the Lake Shore Hospital Emergency Room physician's roster, on January 13, 1987 - despite the hospital board's announcement, one day earlier, of the **two-year reappointment** of the Petitioner's privileges to practice, on January 12, 1987 - the administrator and the two physicians used

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[4] In the Churchill Livingston publication entitled, **"Amputation Surgery And Rehabilitation: The Toronto Experience,"** on page 148, with regard to the **"Indications for Amputation,"** the following account is made:

Amputations in acute injuries of the hand are very often a **"fait accompli,"** and replantation is either ***impossible or unjustified.*** In such cases, the surgical decision is ***not whether but where to amputate.*** The same applies to those cases in which the digit or part of it [sic, is] still attached but badly damaged and avascular. The difficulties in deciding upon whether or not to amputate occur with patients who have a badly damaged but viable digit. Is primary amputation in such cases the best treatment? ***There are no rules.*** One can use certain guidelines, but the decision on whether or not to amputate must be made for each individual patient. A **conservative approach with preservation** of the injured digit, is justified in the following situations. [list omitted] (emphasis supplied)

the Patient B scenario, as one of several pretextual **"justifications"** for removing the Petitioner, proffering that, **"The results of the repair was certainly less that optimal."**

And as if that abhorrence wasn't enough of an abomination, after the ***Hodge vs. Lake Shore Hospital et al.***, suit was dismissed, by western New York district court Judge John T. Curtin - and the judgment kept unentered for almost 3 years to prevent appeal - during the interim period, however, the administrator, James B. Foster, C.E.O, and the two physicians, Joseph G. Cardamone, M.D., and Lynn Feldman, D.O., retaliatorily, conspired with the associate counsel for the New York department of health, the late Paul R. White, Esq., to draw up that, **Mickey Mouse, "fifth specification,"** of charges of **"revealing personally identifiable information obtained in a professional capacity without prior consent of the patient,"** with regard to Patient B (AP 21), who - thankless creature that he is - was readily induced, by that magnetic kinship of white skin, into making an affidavit stating he had not given this Black Petitioner - who saved his toe against medical odds - consent to reveal personal information - i.e., accidentally not **"whiting out"** his name in Petitioner's federal court affidavit, even then, a totally harmless error, readily correctable pursuant to F.R.C.P. Rule 60 (a), which provides for the correction of clerical mistakes in judgments and **"other parts of the record . . . arising from oversight or omission."** No other persons, but the parties in the federal action, had been privy to that **Mickey Mouse** Patient B oversight, at the time the charge was made. The ***Lake Shore Hospital et al.***, defendants merely conspired with the New York State department of health corrupt, zealots to under color of law, fabricate that **Mickey Mouse** charge.

The hearing committee members found the Petitioner guilty of that **Mickey Mouse, "fifth specification,"** with regard to Patients A and B, while they themselves, **"arising from oversight or omission,"** similarly failed to redact the names of <u>three patients</u> (underlined at AP 30-31) in the front of their, **"report of the hearing committee."** (AP 30-31) Although the regents review committee chairman, Emlyn I. Griffith, Esq., of the New York

State education department, in his (AP 13 -20) **"report of the regents review committee,"** went through the machinations of **"legitimizing" the Mickey Mouse, "fifth specification,"** charge by stating - in reference to the hearing committee members, as being magnificent examples of preserving confidentiality of patients - that, **"The names of three patients are redacted from the list of witnesses set forth at page 3 of the hearing committee report. (AP 30-32) They are identified by the use of letters in said report."**

But little did Emlyn know that something serendipitously had back-fired in the course of his chicanery: Petitioner received two sets of **"hearing committee reports,"** from the New York State department of education, in the U.S. mail: One having the three patients' names redacted (blacked out) and another - the one used in the appendix to this petition - with the names un-redacted (AP 30-31). It was akin to a terrorist being blown to smithereens by his own home-made plastic explosive. Petitioner was given a penalty of 36 months suspension of Petitioner's license to practice medicine in the State of New York - on that **Mickey Mouse, "failure to redact"** charge alone! Regents review committee chairman, Emlyn I. Griffith, Esq., - who, lest it be overlooked, sits on the editorial board of the **New York State bar journal**[5], along and in collusion with associate judge of the State

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[5] In his July/August 1991 **"Editors Note to Our Readers,"** Emlyn I. Griffith, Esq., flaunting his usual gestalt and projecting with much artifice, announces among other things, lead articles that readers will find to be both **"interesting and helpful,"** but which really - for good reasons - are Emlyn's psychopathological pre-occupations. There is an article - Emlyn emphatically emblazes - concerning his Freudian fixation of, **"confidentiality in the courts,"** and its hyper-acute antithesis, **"freedom of information,"** which will give, **"newspapers and the public access to the electronic data of government agencies at all levels."** There is also an article dealing with Emlyn's alter-schizoid-ego, most cogent to this petition for certiorari, **"the right to elect independent arbitral forums,"** but by no means **independent committees of medical experts** in the fields of specialties involved in the defense to even **Mickey Mouse** charges against an accused physician unfortunate enough to be caught in the talons of the New York State department of health's and education's, medical conduct proceedings.

Upon a December 7, 1989 motion made by this Petitioner, in that hoax of a proceeding, to form such an **independent committee of medical**

(continued...)

of New York court of appeals, Judy S. Kaye - concluded that, **"Respondent's [Daniel Hodge] license to practice as a physician in the State of New York be suspended for 3 years upon each specification of the charges of which we recommend respondent be found guilty, said suspensions to run concurrently."** (AP 19) And what about the hearing committee's even larger - three instead of two - infraction?

Most startling, was the fact that the only physician member of the New York State board of regents, the late Gerald J. Lustig, M.D., completely dissented (AP 9) and he was ignored by his rubberstamping fellow board members, and that most cogent dissent, was carefully omitted by the New York State appellate division, third department panel of justices, in their so-called **"opinion,"** and by the State of New York court of appeals, which found that, **"no substantial constitutional question is directly involved."** If the State of New York court of appeals has no **substantial knowledge** of medicine, then how could a presumptuous State of New York court of appeals perceive any **"substantial constitutional question,"** and even worse, maliciously affirm a judgement forcing Petitioner to undertake a psychiatric

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[5](...continued)

experts, Emlyn, in a rash of rapacious ruthlessness, on January 9, 1990, through the conduit of his co-defendant, Howard J. Goodman, Esq., senior attorney in the legal services division of the New York State education's, office of professional discipline, broadcasted that, **"It is the ruling of the chairman [of the regents review committee, i.e., Emlyn] to deny those motions in all respects."**

Moreover, there is also an article scrutinizing another sentimental Emlyn-favorite: **"intellectual property,"** such as a trademark which, of course, is quite analogous to a Juris Doctor and Medical Doctor degree, and that - most threatening to the white aristocratic community - combination thereof, i.e., M.D., J.D., particularly in a Black intellectual and political dissident, whom Emlyn has maliciously destroyed, and next to whom Emlyn is - and rightly perceives himself as - a mere dwarf or white elf. Furthermore, editorially speaking, there are those thorny problems of **"legal ethics,"** and the proposed remedial solutions to those problems - of pervasive corruption and criminality in the legal profession - resolutions which are proposed as being realizable somewhere along the lines of a mere precatory **"Bar Exam as a Test of Competence,"** when in actuality, a stiff jail term for Emlyn - and all others of his ilk - is the easy cure for such criminality, as it is for any of all-a-gods other miscreants, on earth, as it is in heaven.

counselling program even if Petitioner passes a psychiatric examination. (AP 11)

Conflicts of interest and special relationships already abound in the so-called **"higher professions,"** sphere, and is itself more evidence of the potential for a widespread range of elitist, white-collar, under color of law, conspiratorial corruption and criminality, motivated by professional jealousy and race hate. In this case, none of the reviewers are physicians (except for the now deceased Gerald J. Lustig, M.D., who - it must be reiterated - completely dissented from the vote of the New York State board of regents). Respondent Emlyn I. Griffith, Esq., is also chairman of the **special committee on attorney professionalism**, whose **"professionalism"** sub-committees are in turn chaired by David B. Filvaroff, as **competency & ethics** subcommittee member - and the dean of the State university of New York law school at Buffalo - and, Respondent Henry A. Fernandez, as **delivery of legal services** subcommittee member, is also deputy commissioner of New York State education department. The conspiracy by the aristocracy to unjustifiably and irreversibly scar and render this Black Petitioner's MD license useless, as they simultaneously prevent Petitioner from securing his JD degree, **ain't no mere serendipity!** It is a premeditated criminal scheme.

REASONS FOR GRANTING CERTIORARI

POINT I: The State Of New York Court Of Appeals Denied Petitioner, Constitutionally-Protected, *Scientific Substantive Due Process*, By Not Granting Petitioner's Repeated Motions To Form An *Independent Committee Of Medical Experts* In The Fields Of Infectious Diseases, Immunology, Cardiology, Pulmonary Medicine And Endocrinology To Apply the *Best Evidence Medical Standards* In Critically Analyzing Petitioner's Scientific Defenses To Fabricated Charges And Pretended Offenses Of Professional Medical Misconduct.

The standard by which scientific physicians measure whether or not another physician practiced scientifically supportable medicine, in a bona fide professional medical conduct proceeding, is not as Justice Harvey et al., of the

woefully corrupt New York State appellate division, third department, proclaim as being by the, **"Testimony from a medical expert, petitioner's co-workers and colleagues,"** (AP 5) - whose statements are clearly not consistent with those found even in the Physician's Desk Reference (PDR), a self-serving trade publication - or in a simple textbook in Internal Medicine, forget about sub-specialty, ultra-esoteric texts in bacteriology, immunology, cardiology, pulmonary medicine and endocrinology (hormone specialty). The way to properly prove, by the use of scientifically neutral facts and medical judgments, whether a physician, in a professional medical conduct proceeding **"took appropriate histories, performed required physicals examinations, performed appropriate diagnostic tests and prescribed necessary medications,"** is to open up a reliable, valid, credible and specific **Best Evidence, medical standard** textbook, or a **medical journal** and prove it!

In ***Goss vs. Lopez,*** 419 U.S. 565 (1975), Mr. Justice White, had written for the Court, **"that the interpretation and application of the Due Process Clause are intensely practical matters and that, '[t]he very nature of due process negates any concept of inflexible procedures universally applicable to every imaginable situation,' *Cafeteria Workers v. McElroy,* 367 U.S. 886 (1961)."** The dissenters in ***Goss vs. Lopez,*** had proffered that, **"In mandating due process procedures the Court misapprehends the reality of the normal teacher-pupil relationship. There is an ongoing relationship, one in which the teacher must occupy many roles-educator, advisor, friend, and, at times parent-substitute,"** which implies that when little Johnny deserves a smack on the behind, he gets it pronto, and at least, he'll remember getting smacked, although he may promptly forget why. Under those circumstances - involving no property and minimal liberty interests - in that setting, cogent arguments can be made that denial of a due process, **"opportunity to be heard,"** is reasonable, to be sure. Well, Johnny might, in fact, have an **"opportunity to be heard,"** down the hall screaming, maybe.

But in the instant case, a very substantial property

interest is at stake - a five million dollar medical license, a priceless professional reputation liberty interest (Amendment 14) - and the joy of professional functionality, which also is inestimable, as for example, re-attaching a patient's toe, after being told to make a stump instead, and seeing it miraculously survive, performed in a age of microsurgery - without microsurgery. It is an indescribable ecstacy. And it matters little that the patient was thankless, because the success satiated the soul irreversibly. There is also the most important factor of educational achievement and the preservation of an untarnished personal and professional reputation. So, the due process opportunity to be misunderstood and ignored by an officious & pretentious, ill-educated hearing committee, a so-called just as ill-educated **"medical expert,"** a bunch-a-lawyers, social workers & retired judges playin' doc, on the New York State board of regents, ain't no way to have old fashion justice in a modern scientific democracy. ***Cafeteria Workers v. McElroy,*** supra. The only physician on the New York State board of regents, the late, Dr. Gerald J. Lustig, M.D., dissented. He no doubt refused to be part of a sham operation - which any scientific physician of good will could readily understand and fathom.

This assortment of fraud and criminality in the so-called, **"higher professions,"** goes undetected perhaps because Chief Justice Rehnquist, among many others, has such an unqualified awe for those little gods called doctors. Jurors, who are notoriously overzealous, however, have been a lot more pragmatic about assessing professional and social status of doctors, and particularly now since the AIDS virus has been revealed to be present in a few doctors and dentists, who knowingly continued to perform invasive procedures on their uninfected patients, without the patients knowing that the doctors/dentists were seropositive for the AIDS virus, not to mention that at some point 400,000 needless tonsillectomies were being performed annually. Welcome to the real world.

In ***Board of Curators of University of Missouri vs. Horowitz,*** 435 U.S. 78 (1978), Chief Justice Rehnquist expressed such unwavering trust & devotion to and in the benefits of the

faculty-student relationship and declined to **"further enlarge the judicial presence in the academic community and thereby risk the deterioration of many beneficial aspects of the faculty-student relationship."** That assortment of abstraction and conceptual goodness and benefit of a **"faculty-student relationship,"** or a **"doctor-patient relationship,"** is what, most unfortunately, forms an artificial shield to justice when things get sour, as invariably happens in any relationships. The truth is - when raw human nature surfaces - that those pedantic relationships, fueled by professional jealousy, fear of economic competition, and in Petitioner's case, coupled with overt and occult **race hate,** among other things, all too often tensions reach a level of combative intensity comparable to - in fact, surpassing that of the sometimes open & notorious, but more often, secret & pernicious, husband-wife relationship - of battered wives and brutalized husbands, with which our court systems are swamped and overwhelmed, not to mention the tip of the iceberg Rodney King/police officer relationships. The benefits and/or detriments of any relationships - whether faculty/student, husband/wife, employer/employee, grantor/grantee, citizen/citizen - are factual determinations, presented to, and heard before, a forum capable of making **informed judgments** in the first instance. ***Cafeteria Workers v. McElroy,*** supra. No presumptions can be made about any attributes of any relationship, in generalized, categorical abstractions, even in an old fashioned biblical era, let alone, in a modern scientific democracy.

It is clear beyond cavil, in the instant case, that a specialist in the fields at issue, can far more accurately, credibly, reliably, validly and specifically demonstrate the nuances and **"high tech,"** intricacies of both theoretical and **"intensely practical matters"** of modern medicine and that, for example, a patient in some instances may not require any medication whatsoever, and moreover, that a physician - who is knowledgeably experienced - must not allow ill-educated nurses or even ill-educated physicians, like so-called **"medical expert,"** Milton N. Luria, M.D., to compromise that physician's **professional independence** so as to be pressured into medicating a patient, when such treatment

is patent and blatant medical malpractice, as would have been the case with an asthmatic, Patient P, who's appropriate management with **NO MEDICATIONS,** was perceived and determined by the jealous, ill-educated hearing committee to be **"negligent and incompetent,"** professional conduct - based of the woefully erroneous testimony of the so-called **"medical expert," Milton N. Luria, M.D.**[6]

Petitioner had, in Petitioner's post-hearing brief, presented documentary evidence to the hearing committee that it would have been malpractice to use a drug called aminophylline to treat

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[6] Petitioner, Daniel Hodge, most effectively used the greatest legal engine ever invented for the uncovering of the truth - particularly scientific truths - in a procedure known as **Scientific Substantive Due Process,** a veritable blow-by-blow, exchange-a-data, during that **"erratic"** cross-examination of the New York State department of health's so-called **"medical expert"** witness, Milton N. Luria, M.D., where Patient P's bronchodilator-induced hypoxemia was hotly contested, as the so-called hearing committee, looked on with amazement. Transcript pp. 2291-2293

Luria: Yes, but what I'm -- you made the comment that if you used epinephrine in a patient who is not an asthmatic --
Hodge: Yes.
Luria: -- that it would be possible --
Hodge: Yes.
Luria: -- to change the --
Hodge: Ventilation/perfusion.
Luria: -- ventilation/perfusion --
Hodge: Ratio.
Luria: -- ratio to the extent that one --
Hodge: Would get hypoxia.
Luria: -- could get hypoxia, and **I'd like to see that someplace.**
Hodge: Okay. That -- that -- that --
Luria: 'Cause that may be something theoretical, but **I'm not certain that that occurs in patients.**
Hodge: No, it happens -- it happens in real patients, Doctor, and it happens and it's --
Luria: **I'd kind of like to see that.**
Hodge: Ever heard the term paradoxic hypoxia? Ever heard the term? Paradoxic hypoxia?
Luria: In what context?
Hodge: In the case of treatment of asthmatics, because it's a side effect of -- of the methylxanthines and Epinephrine and the like. When you treat, you have to give these patients increased oxygen so that when they get this ventilation/perfusion inequality, there isn't that huge amount of shunting.

Patient P, who was a hysterically hyperventilating asthmatic (faking, malingering), having a far above normal (85-95) level of oxygen in her arterial blood, namely a pO_2 of 101.9, (pronounced as **"Pee Oh Two"**) as a test called an **"arterial blood gas"** revealed. The New York State so-called **"medical expert,"** Milton N. Luria, M.D., declared that he would have treated Patient P with aminophylline, thereby precipitously causing a drop in the level of oxygen in her arterial blood to a pO_2 of around 60, thus totally without medically valid justification, unwarrantedly making her condition worse and possibly dangerous, since such treatments of asthmatics on a routine bases have been shown to be related to increased severity of asthma and perhaps **deaths.**[7] The ill-educated hearing committee in its report proclaimed, **"Patient P's blood gas analysis indicated that respiratory insufficiency had been present for some time."** (AP 42) Nothing could be further from the scientific truth, as any respiratory physiologist or pulmonologist (lung specialist) routinely knows.

And, of course, Robert Abrams, re-echoes that medical mediocrity and, **"respiratory insufficiency"** heinous hoax, because Bob comes pell mell to defend corruption and criminality no matter how atrocious the conduct of his State clients. How would New York State chief judge Sol Wachtler know **"respiratory insufficiency"** or hyperoxygenemia or hypocarbia, without calling in a pulmonologist or a respiratory physiologist? Well, don't you know that the chief judge doesn't have to know anything such things and can rule anyway, in a scientific democracy. Patient P's arterial blood gas result on room air was **pH 7.434, pCO_2 24.5, pO_2 101.9, HCO_3 16.5**, classical hysterical

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[7] [T]he deleterious effect is an effect of the betasympathomimetic [epinephrine] drug itself. It is possible that the increasing use of betasympathomimetic drugs is contributing to the world wide increase in morbidity (especially severity) and perhaps mortality. ***Regular Inhaled Beta-agonist Treatment In Bronchial Asthma,*** Malcolm R. Sears et al., Lancet 336:1391-96 (1990). See footnote # 11 on pages 22-23 of ***Hodge vs. Lake Shore Hospital et al.,*** for scientific evidence of bronchodilator-induced hypoxemia.

hyperventilation!

In the April 4, 1991 **"Decision"** (AP 4-7) of the New York State appellate division, third department, Justice Harvey states, **"Initially, we find that the Commissioner's determination was supported by substantial evidence."** (AP 5). No, Justice Harvey et al., **"Initially"** or even finally **"we"** can't **"find"** anything in a modern scientific democracy consistent with old fashioned **Justice,** because **"we"** don't know medicine and **"we"** don't know if the State's **"medical expert"** Milton N. Luria, M.D., is an inept liar or a perspicacious genius. Therefore, Justice Harvey et al., cannot pretend to know which of two physicians are correct with regard to something, of which Justice Harvey et al., **admit right off the bat,** that their **"appellate review is limited,"** or a euphemism for conceding total lack of knowledge. Justice Harvey et al., needn't have been ashamed to say **"We dunno,"** and call in an **Independent Committee** of medical experts; doctors do it all day long. **That was the Cardinal question presented!** Should **WE** call in independent experts when **WE** don't have the knowledge and acumen to verify who is scientifically correct, using the **Best Evidence** scientific data as **The Standard**?

Justice Harvey et al., platitudinously further recite the tunnelesque, **diminutive dimensions of their scope of review** - as if it is hot news, right off the press, proclaiming, **"It is settled that, despite petitioner's disagreement with Lurin's [sic] medical conclusions, the weight to be accorded the testimony of an expert is the responsibility of the triers of fact to determine and is beyond the purview of our limited scope of review in circumstances such as these."**(AP 5). And what if as alleged, and documentarily proved, by the Petitioner, Daniel Hodge, that the **"trier of fact,"** that so-called hearing committee, **doesn't know which way is up about medicine?** How would the presumptuous New York State appellate court reviewers know that? What would the outcome be then, constitutionally and jurisdictionally speaking? Would the New York State appellate court have **legally gained subject matter jurisdiction** over subjects that it outrightly admits it - in so many words - knows nothing about?

Petitioner most emphatically maintains that if there is a professional misconduct charge - albeit Mickey Mouse - being

leveled against the Petitioner, which requires a **detailed scientific defense** to refute it, then the administrative reviewers and the New York State appellate court, must grant a motion to form a very narrowly tailored, independent review mechanism, separate and apart from the state-sponsored **"trier of fact,"** which is capable of validly, credibly, reliably and specifically analyzing the ***best evidence*** esoteric and arcane defense, or otherwise the administrative or judicial review process is at best merely a patently unconstitutionally vague ceremonial kangaroo proceeding, as was had at every level below in this **"Rodney King"** brutalization of this exemplary, scientific Black physician/attorney, Daniel Hodge, in this national disgrace.

POINT II: Petitioner's Due-Process-Required "Opportunity To Be Heard," Actually And Constructively Vanished Before An Ill-Educated, So-Called Hearing Committee Which Fabricated Medical Data And Concocted Meaningless Clinical Circumstances, Found Petitioner Guilty Of Specifications With Which Petitioner Was Not Even Charged, And Never Used A Single Textbook, Journal Or Periodical To Support Its Conclusions, And Even Then, Considered The New York State Prosecutor's Just As Ill-Educated And Malicious, So-Called Medical Expert, As "Our Own Medical Expert."

Bad enough that the members of the hearing committee were documentarily shown to have **severe substantive medical knowledge deficiencies** in almost every case that the hearing committee heard and reviewed, but the hearing committee fabricated medical data and concocted meaningless clinical circumstances, to maliciously **"help out"** the State of New York department of health's, associate counsel for the office of professional medical conduct, the late Paul R. White, Esq.

When the ruthless Mr. Paul R. White, Esq., arrogatedly scheduled and carried out a disciplinary hearing session in the absence of the Petitioner, Daniel Hodge, the hearing committee so gruesomely misplaced its perceived duties and function as to even position itself to play the role of Mr. James A.W. McLeod, Esq., who was Petitioner's counsel at the time. Said hearing committee member, Buffalo surgeon, William C. Heyden, M.D.,

while dispensing a procedural hoax, **"We're just talking -- we're thinking. We're trying to take Mr. McLeod's place."** (transcript p. 621, line 21-22) Talk about Due Process!

One case which also most ably illustrates the penchant of the hearing committee to use **scientific fraud** to **"support and justify,"** its conclusions, is Patient I, who was treated for a severe sore throat, at Tri-County Memorial Hospital, in Gowanda, N.Y., by Petitioner, Daniel Hodge. Petitioner gave Patient I, two 1-gram-shots of Claforan, one in each buttock and she was cured in 3-4 days. Patient I, had previously been treated twice over a period of a week, by two white doctors, and she had developed a skin rash in reaction to the amoxicillin - a semi-synthetic derivative of penicillin - while Patient I's throat became progressively worse, and she couldn't even swallow her saliva because of the excruciating pain.

Patient I, wrote a letter several weeks later - not complaining about the two white doctors who had caused her to sustain a skin rash and drug reaction, while continuing to suffer excruciating pain and no cure - but instead complaining that Petitioner, Daniel Hodge, **"was rude to her, and acted like she shouldn't have come to the hospital."** When the State of New York department of health's, associate counsel for the office of professional medical conduct, the late Paul R. White, Esq., made rounds to gather up his **Mickey Mouse** charges in furtherance of the objectives of his conspiracy with the New York State department of correctional services, then Dr. Lynn Feldman, D.O., who ran the Emergency Room at Tri-County Memorial and Lake Shore Hospital, and who was sued in ***Hodge vs. Lake Shore Hospital Inc. et al.,*** both conjured up multiple schemes, including the Patient I charge (AP 23) based on the **"facts"** in the Patient I letter, namely, the **"rudeness,"** and the **"possibility"** - not actuality - of Patient I sustaining a reaction to Claforan, a drug in the **"penicillin family,"** and secured her testimony in the professional medical conduct proceeding.

In its usual overzealous and pedantic endeavor, to at any cost secure a conviction on the Patient I charge, the hearing committee declared, **"Despite Patient I's recent history of a reaction to Amoxicillin Respondent injected Patient I with a**

single dose of Claforan. The use of Claforan was inappropriate for the following reasons: Patient had received an inadequate trial of Erythromycin, a single dose of Claforan with a half-life of 2-3 hours is not indicated in the treatment of any infection, and Claforan may cause an allergic reaction in individuals with sensitivity to drugs in the penicillin family." (AP 47)

All those hearing committee's statements are in fact, pseudo-scientific fraud. Here's why. Claforan is the trade name of a **"miracle drug,"** the generic antibiotic cefotaxime, which is classified - based on its activity against certain bacteria - as a **"third generation,"** cephalosporin. That class of antibiotic, having a chemical structure - and some biologic and clinical properties - similar to penicillin, was isolated in 1948 from the fungus Cephalosporium acremonium, found in the sea near a sewer outlet off the Sardinian coast. The Physician's Desk Reference (PDR) lists the half-life of Claforan as **"approximately one (1) hour"** and the seventh edition (1985) of Goodman and Gilman's, **The Pharmacological Basis of Therapeutics,** the Bible of pharmaceuticals, records the **half-life of Claforan as 1.1 hours.** The hearing committee's **"half-life of 2-3 hours,"** is obviously patently false. Even a child could appreciate that.

Moreover, the hearing committee's pompous, declaratory statement that, **"a single dose of Claforan with a half-life of 2-3 hours is not indicated in the treatment of any infection,"** suffers from the same fatal flaw: It is patently false. Thousands of **single doses** of Claforan are given daily for gonorrheal infections all over the world. Even a decade ago in 1980, two studies, one involving **192 patients** with gonococcal urethritis, in Hamburg, German and another comprising **211 patients** in Stockholm, Sweden reveal Claforan's **single dose** effectiveness and extremely low drug hypersensitivity rates. No drug reactions were attributable to Claforan. ***Journal of Antimicrobial Chemotherapy***, 6, Supl. A, 291 (1980).

The hearing committee's other ill-educated, out-of-clinically-valid medical context and fragmentary knowledge proclamation, that it was inappropriate to treat with Claforan because, **"Claforan may cause an allergic reaction in individuals with sensitivity to drugs in the penicillin family,"** classically

epitomizes the notion of bluffing clinical acumen and using the Physician's Desk Reference (PDR), **WARNING,** scare tactics, out-of-medically-valid context - the assortment of conduct which is commonly seen in academic circles - while in actuality lacking complete, cogent knowledge of a detailed, empirical and clinically pragmatic nature.

The **WARNING** states that, **"THIS PRODUCT SHOULD BE GIVEN WITH CAUTION TO PATIENTS WITH TYPE I HYPERSENSITIVITY REACTIONS TO PENICILLIN."** Type I Hypersensitivity reactions, also known as **anaphylaxis** - is a rather sudden onset, within 10 - 15 minutes after administration of the drug, of a violent, choking, shocky, low-to-no blood pressure state - which can occur **only in a person** whose immune system is able to innately synthesize a class of antibody called **IgE,** (which stands for Immunoglobulin **"E"** and is pronounced as written, **"eye gee eee"**). The more knowledgeable and experienced physicians, recognize those **standardized warnings** in the (PDR) to, at best, be woeful fragmentary escapades which are of little clinical significance in terms of numbers. Although it is true, as a practical matter, that any reaction likelihood is a 100% for the person unfortunate enough to undergo and experience a reaction, doctors must, nevertheless, constantly **weigh the costs and benefits** of therapy, and for the proper indication, must at times treat a patient <u>despite</u> the likelihood of adverse reactions, when the benefits outweigh the costs and/or adverse side affects.

There is, however, a marked **variability of likelihoods** of causing hypersensitivity reactions among the several derivatives of cephalosporins, and Claforan, which has been around since 1980, has a <u>very low</u> probability of causing hypersensitivity reactions, being listed as merely having a 1.8% chance in the 40th Edition (1986) of the Physician's Desk Reference (PDR) and a 2.4% chance in the 44th Edition (1990), for <u>all</u> hypersensitivity reactions, including **anaphylaxis,** which to date - for **"miracle drug"** Claforan, after hundreds of thousands of doses - number less than ten (10), according to Hoechst-Rousell Pharmaceuticals Inc., its manufacturer. It must be noted that similarly to the **Consumer's Union Magazine,** which independently evaluates consumer products, in an objective manner, some medical

publications such as **The Medical Letter on Drugs and Therapeutics,** and various journals, also **independently evaluate** medical products, services and procedures.

One such independent study which yielded results that can be narrowly tailored, in this case, toward framing the **medical issue** for a decisional **yes or no response,** of whether Claforan can cause **anaphylaxis**, was reported in the December, 1985 Article in the **Reviews Of Infectious Diseases** entitled, **"Cross-Allergenicity and Immunogenicity of Aztreonam,"** by N. Franklin Adkinson, Jr., Andrew Saxon, Michael R. Spence, and Edward A. Swabb. The study, among other things, reveals that after ten days of **treatment with Claforan** (Cefotaxime Sodium), that no **drug-specific IgE antibody**, i.e., IgE to Claforan, was found in a homologous radioallergosorbent assay (that's just a fancy name for a method of **testing for the antibody** in the patient's blood samples), although, **penicillin-treated individuals** had significant levels of posttreatment **IgE penicilloyl antibody,** i.e., drug-specific penicillin antibody: IgE to penicillin. This strongly suggests that Claforan (Cefotaxime Sodium) may be well tolerated by penicillin-allergic patients **with little risk of cross-allergenicity** with penicillins.

These concepts are unfamiliar to most people but stated in simpler terms, in order to be able to suffer an **anaphylactic** reaction from treatment with penicillin, a person, as a pre-requisite, must have the **innate capacity** to **make IgE antibody to penicillin,** in the first place. And the Adkins study, revealed that even persons who had the **innate capacity**, and were known to actually **make IgE to penicillin** - those same persons - did not, however, have the **innate capacity** needed to **make IgE to Claforan** and therefore, a person who **makes IgE to penicillin,** could not by definition have **anaphylaxis** from treatment with Claforan, because Claforan does not induce the formation of the pre-requisite for anaphylaxis: **IgE to Claforan.**

Now, narrowly framing the **medical issue** as to whether Patient I, in the **statement of charges,** who had an alleged allergic reaction and rash from amoxicillin, could also have **anaphylaxis** to Claforan? According to this study the **theoretical answer is NO.** Amoxicillin, as mentioned, is a semisynthetic

penicillin derivative, and the Patient I rash was, from Petitioner's experienced eye, of the **morbilliform** variety of unknown etiology and unrelated to IgE, but a doc would have to know that! The real clinical test is that **Patient I had no reaction whatsoever** and was actually cured in 3-4 days.

And Petitioner, Dr. Daniel R. Hodge, for that stellar performance, nevertheless, had his license to practice medicine suspended for 36 six months for that **Mickey Mouse charge.**[8]

Physicians have promoted themselves for years as being

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[8] The point of this Claforan revelation is that the members of the hearing committee - who haven't cracked a medical textbook or read a cogent journal in years - knew nothing about Claforan's actual hypersensitivity record, either theoretically or clinically, but attempted, off-the-cuff, to bluff their way through - as in all of their report - with the ulterior motive of supporting the Patient I charge, based on **"rumors in the medical non-specialty and lay community,"** about the possibility however remote and unconstitutionally vague, of having an anaphylactic reaction to an antibiotic, **"in the penicillin family,"** in a most generalized, conceptually abstractive manner.

The other hearing committee claim, that Patient I, **"had received an inadequate trial of erythromycin,"** a bulky pill, being taken by any person not able to even swallow her or his saliva, is so obviously ridiculous, to even a child, particularly to a child, which would for the same aversion to swallowing a bulky pill, prefer a cherry or other flavored elixir.

The actual and pseudo-scientific fraud being committed by the hearing committee is, indeed, most apparent, to even a mere child. What makes the hearing committee's criminality so atrociously abominable, is that the hearing committee members - several months before they found guilt on the Patient I charge - were given a copy of the December, 1985 Article in the **Reviews Of Infectious Diseases** entitled, ***"Cross-Allergenicity and Immunogenicity of Aztreonam,"*** by N. Franklin Adkinson, Jr., Andrew Saxon, Michael R. Spence, and Edward A. Swabb. The hearing committee's members simply ignored or were too lazy to read or didn't understand it, and of course, felt - as does most of the white aristocracy, in the **medical** and **legal** arenas - that they can prevail in any controversy and under any circumstances, based solely on their **whiteness** and not their **rightness or brightness,** and since **"white is right,"** by definition, no matter how atrocious the white assertions, then the **"white is right,"** hearing committee report, however sloppy, inaccurate, malicious or criminal, would be affirmed as being lawful, all the way up to Bill Hubbs Rehnquist, in the cirrus clouds of the **Supreme Court of the United States,** where - at least so far in Petitioner's six-year-long struggle for Justice - the racist overt, covert & occult, **liberal left** and racist overt, covert & occult, **conservative right** meet in unanimous ecstacy, when it involves abrogations of Black rights. Associate Justice Clarence Thomas may help to change that, in our scientific democracy!

God-like creatures, who will at any cost - no matter how hazardous, futile, pyrrhic or pointless - preserve life! Although some physicians may be willing to themselves take **"heroic"** personal risks in rescue situations - even though having neither the equipment, trained crew or requisite protection to safely execute such an undertaking - it defies common sense, is professionally wrong and **legally forbidden**[9] to enlist unprotected, untrained and unequipped health care workers to **disregard** Center for Disease Control (CDC) guidelines, and the United States Department of Labor/ Department of Health and Human Services, Joint Advisory Notice on protection against occupational exposure to Hepatitis B (HBV) and Human Immunodeficiency Virus (HIV).

The hearing committee found Petitioner **"guilty"** of negligence and incompetence, in the Patient C, Attica Prison inmate case, (AP 33,34,45,55) although the Petitioner, Daniel Hodge, ventured **beyond the constraints** of the Center for Disease Control (CDC) guidelines by - without having a mask, or eye wear, only gloves - preparing, nevertheless, to carry out an intubation (placing a breathing tube into the patient's **"windpipe"**) - a risky procedure under any circumstances, where a mucoid-projectile of an infectious glob, awaits landing in the rescuer's mouth, nose and eyes - and Petitioner, only did not proceed further, because the **requisite instrument** for successfully completing of intubation - a stylet - was nowhere available in Attica Prison. Nor were there appropriate cardiac medications, nor a defibrillator - **the only definitive treatment for ventricular fibrillation** - documented to be occurring in Patient C.

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[9] **The United States Departments of Labor, and Health and Human Services** in their 1987 **Joint Advisory Notice** recommend that when the nature of the task or activity involves **direct contact** with blood or other body fluids to which **universal precautions apply**, then **personal protective equipment *must*** be available and worn. Emergency medical and public-safety workers, **must consider *all* body fluids** as hazardous and must use universal precautions. Therefore, when emergency medical and public-safety workers encounter body fluids under uncontrolled, **emergency circumstances** in which differentiation between fluid types is difficult, if not impossible, they should treat **all body fluids** as potentially hazardous.

And the most important inquiry is this: How can guilt of professional misconduct be attached by New York State to a physician for even exceeding the prohibitions of federal guidelines? In essence New York State officials are saying, **"Doctor, you didn't violate federal laws and guidelines to enough of an extent to be free of State culpability for not going forward with an unequipped, untrained and unprotected - and by CDC definition - hazardous rescue operation."** In other words, Petitioner's compliance with a **federal obligation** - not even exercise of a **federal right,** as in ***Georgia vs. Rachel,*** 384 U. S. 780 (1966) - was deemed to be a State law violation. That is the epitome of **"Northern Liberal,"** criminality, where State prosecutors are in essence forcing a citizen to violate federal law to avoid **"Northern Liberal State culpability"** in the very same federally operative factual circumstance. And appellate division, third department panel of justices, Hon. John T. Casey, Leonard A. Weiss, Thomas E. Mercure, Norman L. Harvey and D. Bruce Crew III, who can very well read plain English in the federal guidelines, which has language of an unmistakable mandatory character, nevertheless, rubberstamped that kind of **"State culpability,"** as did the just as corrupt State of New York court of appeals.

Even more barbarous, the members of the appellate division, third department panel of justices penalized Petitioner for exercising Petitioner's federal right of conducting vigorous **scientific substantive due process** in cross-examination[10] of the

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[10] Administrative Judge Harry A. Allan, of all the persons involved in the office of professional medical conduct (OPMC) proceeding was the only truly impartial participant. In paragraph 4 of his affidavit, sworn to on April 22, 1991, and made at Petitioner's request, Judge Allan stated that, **"Dr. Hodge did an adequate job of representing himself from that point on to the conclusion of the hearings; he respected the rulings of this Administrative Judge and the Chairman; his conduct was consistent with that of any attorney representing a client; at no time was he unprofessional nor did he at any point conduct himself in violation of the canons of professional ethics."**

Several times during the proceeding - particularly when the New York State department of health's so-called **"medical expert,"** was being nailed to the cross, in the most vigorous of cross-examinations and re-cross-examination, by

(continued...)

State's so-called **"medical expert,"** and justified - under the cloak of majoritarian legitimacy - imposing the penalty of **"psychiatric counselling, even if [Petitioner] passes a psychiatric examination,"** and practice monitoring, because Petitioner had a **"personality disorder of the narcissistic type,"** and that the, **"hearing committee specifically found that diagnosis credible in light of the erratic behavior Petitioner displayed during the course of the hearing."**

Even though the best evidence scientific proof of innocence is readily found in textbooks, and despite that exoneration of the Petitioner by **"the Pontiff,"** the hearing committee found guilt anyway and the hearing committee's

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[10](...continued)
this relentless Pro Se gladi-litigator, the New York State department of health Associate Counsel, the late, great miscreant Paul R. White, Esq., would start yelling like a maniac and the Administrative Law Judge, Harry Allan, would have to command him to stop yelling. **"Mr White, please don't yell."** . . . **"I understand, but you're not helping the situation when you yell out like that."** T 2120:20-25;2121:1 And again later on in the proceeding - and when off the record as well - at T 2703:12-13, **"All right. Mr. White, first of all, don't raise your voice."**

The only **"erratic behavior,"** exhibited during the year-long hearings, was the utterly infantile fanfare and spectacular tantrums being carried out, and on, by the New York State white-collar, conspiratorial criminal, the late, great miscreant Paul R. White, Esq., and his so-called **"medical expert,"** Dr. Milton N. Luria, M.D., - whose byname of **"the Pontiff,"** was bestowed upon him by this Petitioner for Dr. Luria's proclivity to make empty, scientifically fraudulent declarations and whose multiple proclamations were codified in Petitioner's post-hearing brief as **The Ten Commandments of Luria, and much, much more,** numbering a total of 51 - the 43rd of which is most illustrative of the tone, timbre and ambience of that **"erratic"** proceeding: **"I -- Judge, Dr. Hodge, if -- if this was all the information and this is all the information that was available, and if this is, in fact, all that one -- information that anybody has or did have on that day, I think it's fair to say that these could be two independent decisions, and they would be valid and correct,"** T 2135:21-25;2136:1-2. The Pontiff was thus compelled and cornered into finally admitting that a patient (Patient N in the statement of charges, AP 24, 40, 49-50) with a decompensated pancreas could develop a serum glucose (sugar in the blood) of 200, even 300 **in one hour** T 2126:19-25;2127:1-7. This means that a **urine test would be negative** during the first presentation, and of no value whatsoever - as any decent physician very well knows - in predicting that **first time onset** of diabetic keto-acidosis, some 24 hours later - and that **cogent admission,** just completely destroyed the State's ridiculous charge. The hearing committee was flabbergasted and furious.

conduct has thus been shown to be criminal fraud, with which the review courts have conspiratorially assented. The foregoing identical pattern and outcome can be scientifically demonstrated in each and every charge. Such hearing committee conduct merits a jail term because of the magnitude of the **Property Interest** ($ 5 Million license to practice medicine, ***Board of Regents vs. Roth,*** 408 U.S. 593 (1972), ***Perry vs. Sinderman,*** 408 U.S. 593 (1972), equivalent to a Brinks or Wells Fargo robbery, perpetrated in broad daylight) which they conspired to unlawfully take away from another citizen, without **scientific substantive due process,** under the guise of a legitimate professional medical conduct proceeding. ***Goldberg vs. Kelly,*** 397 U.S. 254 (1970). Each reviewer will be put on that heavenly hot seat to answer medical questions, as sure as there are stars up above. If the hearing committee, and the whole entourage of reviewers up the tiers of ambition, didn't have a legitimate, medically justifiable reason for finding Petitioner guilty, then they must have found guilt for some other purpose. It was, of course, to assist the New York State department of health, to further assist the New York State department of correctional services, to **"get rid of Dr. Hodge,"** and to simultaneously destroy his **medical** and **legal** careers.

The hearing committee didn't even attempt to disguise its conspiratorial conduct and had no problem whatsoever considering itself as a uniform part of the prosecutorial arm of the State, and even **openly declared** its **unity of structure,** let alone consonance of **purpose** and **function** in cohesion with the State prosecutor. Hearing committee internist, Dr. Margaret H. McAloon M.D., director of physician's services at State University of New York at Buffalo medical school, blurted out, **"What we now have here is our own expert witness who you should be focusing your question to areas that he testified to."** (emphasis supplied) Transcript p. 1666:12-15

POINT III: Since Nobody Is Above The Law, The State Of New York Court Of Appeals, The Appellate Division, Third Department Justices, The New York State Commissioner Of Education, The New York State Board Of Regents And The Regents Review Committee Are Just As Guilty As The

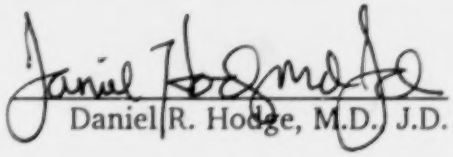
Reviewers Below Them Of Civil Misconduct Under 28 U.S.C. 1343 And Criminal Misconduct Under 18 U.S.C. 241-242 For *Scientific Fraud*, Perpetrated In A Conspiracy, Under Color Of Law, Most Reprehensibly From Behind The Bench.

All judicial officers must uphold the Constitution and laws of the United States of America, as is provided in Article VI, section 3, "The Senators and Representatives before mentioned, and the members of the several State Legislatures, and all executives and judicial officers, both of the United States and of the several States, shall be bound by oath or affirmation to support this Constitution." In *Ex Party Siebold*, 100 U.S. 371 (1880), Justice Bradley had written for the Court that, "The Constitution and laws of the United States are the supreme law of the land, and to these every citizen of every State owes obedience, whether in his *individual* or official capacity." In *Ex Party Young*, 209 U.S. 123 (1908), Justice Peckham, speaking for the Court said that, "[t]he use of the name of the State to enforce an unconstitutional act to the injury of the complainants is a *proceeding without the authority* of and one which does not effect the State in its sovereign or governmental capacity." By refusing Petitioner's repeated motions for independent expert medical analysis and review, the New York State administrative and judicial reviewers - none of whom are physicians - carried out ***totally unlawful proceedings without the authority of subject matter jurisdiction***, in a widespread conspiracy, designed to severely and irreversibly harm the Petitioner, in violation of federal laws. 28 U.S.C. 1343, 18 U.S.C. 241-242 (AP 65-67)

CONCLUSION

For all the foregoing reasons, a writ of certiorari should be issued for this Court to exercise its power of supervision, to return to Petitioner his unscarred medical license and unblemished medical reputation, enabling Petitioner as an independent professional, to again practice medicine in the exemplary fashion of the past.

Dated: Buffalo, N.Y.
September 14, 1991



Daniel R. Hodge, M.D., J.D.

State of New York
Court of Appeals

Donald M. Sheraw
Clerk of the Court

Clerk's Office
Albany, New York 12207

3-10 Mo. No. 619
In the Matter of Daniel R. Hodge,
Appellant,
v.
New York State Department of Education et al.,
Respondents.

On the Court's own motion, appeal as of right dismissed, without costs, upon the ground that no substantial constitutional question is directly involved.
Motion for leave to appeal denied.

DECISION COURT OF APPEALS JULY 9, 1991

At a Term of the Appellate Division of the Supreme Court of the State of New York held in and for the Third Judicial Department at the Justice Building in the City of Albany, New York, commencing on the 4th day of February, 1991

PRESENT:

HON. JOHN T. CASEY

Justice Presiding

HON. LEONARD A. WEISS
HON. THOMAS E. MERCURE
HON. D. BRUCE CREW, III
HON. NORMAN L. HARVEY

Associate Justices.

In the Matter of the Appellate of
DANIEL R. HODGE, M.D., J.D. et al

Petitioners, JUDGMENT

-against- No. 61591

NEW YORK STATE DEPARTMENT OF EDUCATION, and NEW YORK STATE BOARD OF REGENTS, et al.,

Respondents.

The above-named petitioner having instituted a CPLR Article 78 proceeding in this Court pursuant to Section 6510-a(4) of the Education Law to review a determination of the respondents which inter alia, suspended his license to practice medicine in the State of New York;

NOW, on reading and filing the Notice of Petition and the

petition of DANIEL R. HODGE, M.D., J.D., verified the 26th day of July, 1990, and the exhibits annexed thereto, and the answer of the respondents verified the 11th day of September, 1990, and the said proceeding have been presented during the above-stated term of this Court, and having been argued by DANIEL R. HODGE, attorney pro se for petitioner, and by John J. O'Grady, Esq., Assistant Attorney General, of counsel for the respondents, and, after due deliberation, the Court having rendered a decision on the 4th day of April, 1991, it is hereby

ORDERED that the determination be confirmed and the petition be dismissed, without costs.

ENTER

/s/ Michael J. Novack

CLERK

DATED AND ENTERED: April 23, 1991

AP 4

Supreme Court - Appellate Division
Third Judicial Department

April 4, 1991 61591

In the Matter of DANIEL R. HODGE,

Petitioner,

v

NEW YORK STATE DEPARTMENT OF EDUCATION et al.,

Respondents.

HARVEY, J.

Proceeding pursuant to CPLR article 78 (initiated in this court pursuant to Education Law Section 6510-a [4]) to review a determination of respondent Commissioner of Education which, inter alia, suspended petitioner's license to practice medicine in New York for three years.

Following a hearing before a Hearing Committee of the State Board for Professional Medical Conduct, petitioner, a physician licensed to practice in New York, was found guilty of negligence on more than one occasion with respect to nine patients, incompetence on more than one occasion with respect to three patients, fraudulent practice with respect to one patient, unprofessional conduct in failing to maintain an accurate medical record with respect to one patient, unprofessional conduct in verbally harassing, abusing or intimidating two patients, and revealing personally identifiable information about two patients without their permission. Ultimately, respondent Commissioner of Education suspended petitioner's license to practice medicine for three years with execution of the last 33 months stayed, at

which time petitioner was to be placed on probation for 33 months with certain conditions. Petitioner thereafter commenced this CPLR article 78 proceeding seeking principally to annul the Commissioner's determination.

Initially, we find that the Commissioner's determination was supported by substantial evidence. In proceedings such as this, appellate review is limited and the Commissioner's determination must be sustained "if the finding of the physician's deficiencies is supported by substantial evidence in the record" (Matter of Hirose v Sobol, ___ AD2d ___ [Nov. 1, 1990], slip opn p 1; see, Matter of Pell v Board of Educ., 34 NY2d 222, 230-231). Following 17 scheduled days of hearings extending almost a year, petitioner was found guilty of serious deficiencies in his professional practice. Testimony from a medical expert, petitioner's co-workers and colleagues sufficiently established, among other things, that petitioner failed on several occasions to take adequate patient histories, perform required physical examinations, perform appropriate diagnostic tests and prescribe necessary medication.

Aside from petitioner's meritless claim that he was denied due process in the course of these extensive proceedings, petitioner also vigorously attacks the qualifications and objectivity of the State's medical expert, Milton Lurin, who testified as to the inadequacies of petitioner's medical practices. It is well settled that, despite petitioner's disagreement with Lurin's medical conclusions, the weight to be accorded the testimony of an expert is the responsibility of the triers of fact to determine (Education Law Section 6510-a[2]; see, Matter of Stein v Board of Regents of Univ. of State of N.Y., ___ AD2d ___ [Jan. 3, 1991]) and is beyond the purview of our limited scope of review in circumstances such as these (see, Matter of Hirose v Sobol, supra). As for petitioner's claims that the disciplinary proceeding herein was part of a conspiracy against him, we note that no evidence has been submitted by petitioner to support these attacks other than petitioner's own conclusory and unsubstantiated allegations (see, e.g., Matter of Major v Board of

Regents of Univ. of State of N.Y., 160 AD2d 1041, 1043, lv denied, 76 NY2d 705).

Finally, with respect to the imposed penalty, we fail to find it "'so disproportionate to the offense * * * as to be shocking to one's sense of fairness'" (Matter of Pell v Board of Educ., supra, at 233, quoting Matter of Stolz v Board of Regents, 4 AD2d 361, 364) that we will intervene to annul it (see, Matter of Stein v Board of Regents of Univ. of State of N.Y., supra). Petitioner takes particular issue with conditions imposed upon his probation, which included petitioner submitting to a psychiatric examination to determine his fitness to practice medicine and requiring that petitioner participate in a counseling program during the period of probation. Under the unusual circumstances of this case, however, we find the challenged conditions to be reasonable. This court has recognized in the past the use of psychiatric evaluations and therapy as an allowed penalty (see, Matter of Hening v Ambach, 132 AD2d 783, 783-784, appeal dismissed 70 NY2d 926, lv denied 72 NY2d 802, cert denied 488 US 108). Notably, while the hearing was pending, the Hearing Committee ordered petitioner to submit to a psychiatric examination and evaluation. It was the opinion of the examining psychiatrist that petitioner has a personality disorder of the narcissistic type. The Hearing Committee specifically found that diagnosis credible in light of the erratic behavior petitioner displayed during the course of the hearing. The Hearing Committee also concluded that petitioner's narcissistic personality disorder "interfered [sic] with his care of patients in that he relied on an exaggerated sense of his own abilities resulting in his not ordering simple * * * tests and performing adequate physical examinations, all of which resulted in [petitioner] reaching premature conclusions and misdiagnoses".

Clearly, the situation at bar differs from the one presented in Matter of Krasowski v State Educ. Dept. (132 AD2d 120, appeal dismissed 71 NY2d 890) in that not only was petitioner not found to be free of impairment during the instant

hearing process, but there also appears to be some causal link between factual allegations underlying the sustained misconduct and the later order requiring psychological intervention. Accordingly, the probation conditions, including the one requiring that petitioner's practice be monitored by a preapproved physician in the event that his practice is resumed, appear rational under these circumstances and will not be disturbed by this court.

Determination confirmed, and petition dismissed, without costs.

CASEY, J.P., WEISS, MERCURE, CREW and HARVEY, JJ., concur.

AP 8

State of New York
Department of Law
120 Broadway
New York, N.Y. 10271

Robert Abrams
Attorney General

Howard L. Zwickel (212) 341-2564
Assistant Attorney General in
Charge Litigation Bureau

May 2, 1991

Daniel R. Hodge, M.D., J.D.
1645 Statler Towers
Buffalo, New York 14202

Re: Matter of Hodge v. State Education Dep't et al.
No. 61591

Dear Sir:

Enclosed find a copy of the Judgment with Notice of Entry in the above matter. The judgment becomes effective on May 13, 1991 and any stay which might be in effect will be vacated on that day.

We have notified the New York State Education Department concerning this matter.

Yours truly,

JOHN J. O'GRADY
Assistant Attorney General

JJOG:hb
Encl.
cc: Gus Martine
Supervising Investigator

The University of the State of New York

IN THE MATTER

OF

DANIEL R. HODGE
(Physician)

DUPLICATE ORIGINAL
VOTE AND ORDER
NO. 10444

Upon the report of the Regents Review Committee, a copy of which is made a part hereof, the record herein, under Calendar No. 10444, and in accordance with the provisions of Title VIII of the Education Law, it was

VOTED* (April 27, 1990): That, in the matter of DANIEL R. HODGE, respondent, the recommendation of the Regents Review Committee be accepted as follows:

1. The hearing committee's findings of fact numbered 1-78 and 80-87 be accepted and its finding of fact numbered 79 not be accepted because it is conclusory as to possible negligence or incompetence with which respondent was not charged, and the Commissioner of Health's recommendation as to the findings be similarly accepted and not accepted;

2. Finding of fact numbered 9(a) set forth at page 8 of the Regents Review Committee report be accepted;

3. The Conclusions and Summary of Conclusion of the

Regent Gerald J. Lustig, M.D., dissented

hearing committee and the Commissioner of Health's recommendation with respect thereto be accepted to the extent they are consistent with respondent's guilt, as hereafter indicated, and not be otherwise accepted; and

4. Respondent is guilty, by a preponderance of the evidence, of 1) negligence on more than one occasion under the first specification as to patients C, F, G, H, I, L, M, N and P, 2) incompetence on more than one occasion under the first specification as to patients J, L, and P, 3) the second, third, and fifth specifications, and 4) the sixth specification as to patients P and R, and not guilty of the remaining charges;

that the recommendation of the Regents Review Committee be modified as to the measure of discipline as follows:

That, as a more appropriate penalty for the serious misconduct committed, respondent's license to practice as a physician in the State of New York be suspended for three years upon each specification of the charges of which respondent is guilty, said suspensions to run concurrently, and that the execution of the last 33 months of said suspensions be stayed at which time respondent be placed on probation by the Regents Review Committee, except as follows:

that probation term 1b be deleted and replaced by a new term 1b as follows:

That prior to (at respondent's option) or during the first month of probation respondent shall submit to an examination, at respondent's expense, by a psychiatrist chosen by respondent and previously approved, in writing, by the Director of the Office of Professional Medical Conduct, and respondent shall supply, within the first month of probation, a written report from said psychiatrist, said report to state whether or not respondent is fit to practice as a physician in the State of

New York; that respondent must be fit to practice as a physician in the State of New York in order to be in compliance with this term of probation, such fitness to be demonstrated by said report from the psychiatrist; and that if information is received by the New York State Department of Health from said psychiatrist indicating that respondent is unfit to practice respondent's profession, such information shall be processed to the Board of Regents for its determination in a violation of probation proceeding initiated by the New York State Department of Health and/or such other proceedings pursuant to the Public Health Law, Education Law, and/or Rules of the Board of Regents;

that there be added a new probation term 1f as follows:

That respondent shall, at respondent's expense, enroll and participate in a counselling program during the period of probation, said counselling program to be selected and previously approved, in writing, by the Director of the Office of Professional Medical Conduct; proof of the satisfactory completion of said counselling program to be submitted, in writing, to said Director of the Office of Professional Medical Conduct within 10 days after such successful completion. Respondent shall undertake said counselling program even if he passes the psychiatric examination required in probation term 1b;

that there be added a new probation term 1g as follows:

That respondent shall, at respondent's expense, have his practice of medicine monitored, including reviews of respondent's patient records, by a physician to be selected by respondent and previously approved, in writing, by the Director of the Office of Professional Medical Conduct, said physician to submit a written report of such monitoring to said Director at such times as said Director requests;

and that the Commissioner of Education be empowered to execute, for and on behalf of the Board of Regents, all order necessary to carry out the terms of this vote;

and it is

ORDERED: That, pursuant to the above vote of the Board of Regents, said vote and the provisions thereof are hereby adopted and **SO ORDERED**, and it is further

ORDERED that this order shall take effect as of the date of the personal service of this order upon the respondent or five days after mailing by certified mail.

IN WITNESS WHEREOF, I, Thomas Sobol, Commissioner of Education of the State of New York, for and on behalf of the State Education Department and the Board of Regents, do hereunto set my hand and affix the seal of the State Education Department, at the City of Albany, this 4th day of May 1990.

/s/ Thomas Sobol
Commissioner of Education

The University of the State of New York

IN THE MATTER

of the

Disciplinary Proceeding

against

DANIEL R. HODGE No. 10444

who is currently licensed to practice as a physician in the State of New York.

REPORT OF THE REGENTS REVIEW COMMITTEE

DANIEL R. HODGE, hereinafter referred to as respondent, was licensed to practice as a physician in the State of New York by the New York State Education Department.

The instant disciplinary proceeding was properly commenced and between May 26, 1988 and May 12, 1989 a hearing was held before a hearing committee of the State Board for Professional Medical Conduct. A copy of the statement of charges is annexed hereto, made a part hereof, and marked as Exhibit "A".

The hearing committee rendered a report of its findings, conclusions, and recommendation, a copy of which is annexed hereto, made a part hereof, and marked as Exhibit "B". The names of three patients are redacted from the list of witnesses set forth at page 3 of the hearing committee reports. They are identified by the use of letters in said report.

DANIEL R. HODGE (10444)

It is suggested that, in the future, each specification of professional misconduct be separately stated and numbered in the statement of charges and that a hearing committee report avoid making a Summary of Conclusion referring to guilt in such a generalized manner requiring a reference back to the Factual Discussion in order to ascertain specific guilt. It is also suggested that there be a conclusion portion of the report that specifically indicates whether respondent is guilty or not guilty of each specification regarding each patient charged therein. In this regard, the following is noted:

1. The first specification does not include any allegation as to patients A and B. Nevertheless, the hearing committee concludes, in its Summary of Conclusion, that respondent is guilty of negligence and/or incompetence under the first specification as to those patients. The Commissioner of Health, in his recommendation, requested the deletion of patients A and B in said Summary of Conclusions but did not state the reason therefor. This was clarified only upon oral argument before us, during which it was indicated that the reason was because respondent was never charged with negligence or incompetence as to those patients under the first specification;
2. The first specification does not include an allegation as to patient Q based upon negligence and/or incompetence. Nevertheless, the hearing committee and the Commissioner of Health concluded respondent was guilty of negligence as to this patient;
3. Respondent was charged with negligence and/or incompetence as to patient R (first specification), as well as verbal harassment of said patient (sixth specification). Nevertheless, under the Factual Discussion, respondent was found guilty specifically only as to verbal harassment (pages 34-35 of report), which is in conflict with the Summary of Conclusion also indicating guilt, in a generalized manner, as to negligence and/or incompetence under the first specification as to patient R;

4. Respondent was charged with negligence and/or incompetence as to patient I (first specification), as well as verbal harassment of said patient (sixth specification). The Factual Discussion indicates guilt under the first specification but does not specifically indicate that respondent is not guilty of the sixth specification. It is only by the process of elimination, by reference to the language in the Factual Discussion (page 28 of report) and the Summary of Conclusion (page 37 of report), that it is understood that respondent is not guilty of the sixth specification regarding patient I; and

5. The Conclusions discussed at pages 37-42 are confusing in regard to patient A as to an asthma attack (page 38 of report) and that patient causing herself to overbreadth (page 40 of report) since respondent was not charged therewith in terms of negligence or incompetence or harassment; to patient Q as to an infarction (page 38 of report) since such allegation was not part of the first specification and respondent was found not guilty as to the sixth specification as to said patient; to patient E regarding crutches (page 38 of report) when respondent was found not guilty as to said patient; to patient T when no allegation was contained in any of the specifications except the sixth specification as to which respondent was found not guilty; to patient R as to failure to perform a neurological examination (page 39 of report) when respondent was only found specifically guilty regarding verbal harassment; and to patient I in the apparent context of harassment (page 40 of report) for which respondent was found not guilty.

On August 23, 1989 the hearing committee unanimously concluded that respondent was guilty of all six specifications of the charges, to the extent indicated in its report, and recommended that respondent's license to practice as a physician in the State of New York be revoked.

DANIEL R. HODGE (10444)

On November 6, 1989 the Commissioner of Health recommended to the Board of Regents that the findings of fact, conclusions and recommendation of the hearing committee be accepted in full, except with regard to the deletion of reference to patients A and B in the Summary of Conclusions as to the first specification, as set forth in his recommendation, a copy of which is annexed hereto, made a recommendation, no distinction is made between the Summary of Conclusions j(pages 36-37) and the Conclusions (pages 37-42), causing confusion as to whether he is recommending the acceptance of all the conclusions under both headings or under only one of them.

On January 18, 1990 respondent appeared before us in person without an attorney. Paul R. White, Esq., presented oral argument on behalf of the Department of Health.

Petitioner's recommendation, as to the measure of discipline to be imposed, should respondent be found guilty, was that respondent's license to practice as a physician in the State of New York be revoked.

We have considered the record as transferred by the Commissioner of Health in this matter, as well as the numerous submissions of the parties. The record was closed as of January 18, 1990. In his various submissions and at the hearing before this committee, respondent argued that he was not guilty of the charges.

The fourth specification of the charges is based upon an alleged abandonment of professional employment under section 29.2(a)(1) of the Rules of the Board of Regents which reads as follows:

> **(1) abandoning or neglecting a patient or client under and in need of immediate professional care, without making reasonable arrangements for the continuation of such care, or abandoning a professional employment by a group practice, hospital, clinic or other health care facility, without reasonable notice and under circumstances which seriously impair the deliver of professional care to patients or clients.**

In support of this specification, it was alleged that respondent failed to report to work at the Attica Correctional Facility at his scheduled time on February 28, 1986 and February 6, 1987, "necessitating the cancellation of clinic hours at which prison inmates were scheduled to receive medical attention."

In its Factual Discussion regarding this specification, the hearing committee rejected respondent's denial of having been late to work on February 28, 1986, applying the doctrine of collateral estoppel to a finding in an arbitration proceeding between respondent and the Attica Correctional Facility. The hearing committee also determined against respondent with regard to lateness on February 6, 1989, based upon a travel voucher which conflicted with respondent's testimony regarding reporting to work on that date.

We unanimously disagree with the conclusion of guilt that respondent abandoned his employment on the dates here at issue. The arbitration proceeding involved the issue of lateness which, in our unanimous opinion, does not rise to the level of and is not equivalent to abandonment of employment. The question of lateness on the second date is similarly not abandonment of employment. Furthermore, in the instant case, no evidence was presented to establish that respondent abandoned, as distinguished being late in, his employment and the record cannot support such a finding or conclusion.

The fifth specification of the charges is based upon an alleged violation of section 29.1(a)(8) of the Rules of the Board of Regents which reads as follows:

> **(8) revealing of personally identifiable facts, data or information obtained in a professional capacity without the prior consent of the patient or client, except as authorized or required by law.**

Respondent does not dispute the facts as found by the hearing committee but contends that his circumstances fall within the provision of the statutory language "except as otherwise authorized or required by law", in that the nature of

the patient information was disclosed in a legal proceeding wherein the patient's health and treatment were at issue. We do not agree with respondent where, under the circumstances herein, respondent initiated the legal proceeding against his employer in which the patients were not parties and the names of the patients were not redacted. Such failure to redact the patient names is deemed an additional finding of fact numbered 9(a) which is supported by the court papers which are part of this record.

With respect to the measure of discipline to be imposed, it is not possible to assess the weight given by the hearing committee regarding its erroneous conclusion of guilt as to patients A and B based upon negligence and/or incompetence with which respondent was not charges; to assess the weight given by the hearing committee and Commissioner of Health regarding their erroneous conclusion of guilt as to patient Q based upon negligence with which respondent was not charged under the first specification; or to assess whether the hearing committee or Commissioner of Health were aware of what we previously pointed out regarding patients A, Q, E, T, R, and I at page 4 of this report. It would appear that the errors and confusion (pages 2-4 of this report) had an impact on the measure of discipline recommended by the hearing committee and Commissioner of Health. This matter was commenced on April 12, 1988 and it has taken approximately nineteen months to result in the recommendation of the Commissioner of Health on November 6, 1989. In view thereof, we have not considered a remand of this matter (cf. Gould v. Board of Regents, 103 A.D.2d 897 (3rd Dept. 1984) and have proceeded, with due consideration of the record herein and the errors and confusion pointed out at pages 2-4 of this report, to unanimously recommend the following to the Board of Regents:

1. The hearing committee's findings of fact numbered 1-78 and 80-87 be accepted and its finding of fact numbered 79 not be accepted because it is conclusory as to possible negligence or incompetence with which respondent was

not charged, and the Commissioner of Health's recommendation as to the findings be similarly accepted and not accepted;

2. Finding of fact numbered 9(a) recommended by us at page 8 of this report be accepted;

3. The Conclusions and Summary of Conclusion of the hearing committee and the Commissioner of Health's recommendation with respect thereto be accepted to the extent they are consistent with our recommendation finding respondent guilty, as hereafter indicated, and not be otherwise accepted;

4. Respondent be found guilty, by a preponderance of this evidence, of 1) negligence on more than one occasion under the first specification as to patients C, F, G, H, I, L, M, N and P, 2) incompetence on more than one occasion under the first specification as to patients J, L, and P, 3) the second, third, and fifth specifications, and 4) the sixth specification as to patients P and R, and not guilty of the remaining charges; and

5. Respondent's license to practice as a physician in the State of New York be suspended for 3 years upon each specification of the charges of which we recommend respondent be found guilty, said suspensions to run concurrently, that execution of said suspensions be stayed, and that respondent be placed on probation for three years under the terms set forth in the exhibit annexed hereto, made a part hereof, and marked as Exhibit "D". In arriving at our recommendation as to the measure of discipline to be imposed, we have considered the record, the errors and confusion previously addressed in this report, and the nature and extent of the misconduct committed by respondent. Because of our concern as to respondent's behavior toward patients P and R, our recommendation includes, under the probationary terms, psychiatric examination regarding

respondent's fitness to practice as a physician in the State of New York.

Respectfully submitted,

EMLYN I. GRIFFITH
JANE M. BOLIN
PATRICK J. PICARIELLO

Dated: 3/3/90

Chairperson

STATE OF NEW YORK : DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER	STATEMENT
OF	OF
DANIEL R. HODGE, M.D.	CHARGES

DANIEL R. HODGE, M. D., the Respondent, was authorized to practice medicine in New York State on May 12, 1978 by the issuance of license number 134316 by New York State Education Department. The Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1986 through December 31, 1988 from 27A Longmeadow Road, Amherst, New York 14226.

FACTUAL ALLEGATIONS

A. On or about June 2, 1987, a lawsuit was filed on behalf of the Respondent before the United States District Court, Western District of New York. In support of this lawsuit, the Respondent submitted an affidavit in which he disclosed personally identifiable information about Patients A and B (these patients as well as all other patients referred to herein are identified in Appendix A). The Respondent had attended to Patients A and B while he worked in the Emergency Room at Lake Shore Hospital in Irving, New York. The Respondent attached copies of the emergency room records of Patients A and B to his affidavit without redacting the names of these patients. In addition, the Respondent disclosed the medical history, condition and treatment of Patients A and B in considerable detail.

EXHIBIT "A"

B. On February 28, 1986 and February 6, 1987, the Respondent failed to report to work at the Attica Correctional Facility in Attica, New York at his scheduled time, necessitating the cancellation of clinic hours at which prison inmates were scheduled to receive medical attention.

C. On March 2, 1987, at approximately 2:15 p.m., Patient C was brought to the Hospital Unit of Attica Correctional Facility. Patient C was gasping for air, unresponsive, and had a blood pressure reading of 100/70 at 2:17 p.m. The Respondent pronounced Patient C dead at 2:20 p.m. The Respondent:

1. failed to attempt to initiate Patient C;
2. prevented the nursing staff from using an ambu-bag;
3. prevented the nursing staff from using a portable ventilator; and
4. failed to administer cardiopulmonary resuscitation and prevented the nursing staff from initiating this procedure.

D. On April 20, 1986, at approximately 12:15 p.m., Patients D was examined by the Respondent in the emergency room of the Tri-County Memorial Hospital. The Respondent failed to correctly interpret the x-ray examination of this patient's right ankle in that an avulsion fracture off the tip of the distal fibular epiphysis was missed.

E. On April 27, 1986, at approximately 4:30 p.m., Patient E was examined by the Respondent in the emergency room of the Tri-County Memorial Hospital. The Respondent failed to correctly interpret the x-ray examination of this patient's right knee in that a fracture of the proximal tibia was missed.

F. On November 19, 1986, at approximately 1:40 a.m., Patient F was examined by the Respondent in the emergency room of the Tri-County Memorial Hospital. The Respondent failed to perform a thorough evaluation of the swelling to the knuckle of the last finger on the right hand and failed to order and x-ray examination. Patient F was subsequently diagnosed as having a fracture at the base of the right fifth metacarpal.

G. On August 16, 1986, at approximately 5:10 p.m., Patient G was examined by the Respondent in the emergency room of the Tri-County Memorial Hospital. The Respondent failed to perform a thorough evaluation of Patient G's musculoskeletal system and failed to order an x-ray examination. Patient G was subsequently diagnosed as having multiple right-sided rib fractures.

H. On February 8, 1986, at approximately 4:30 p.m., Patient H was examined by the Respondent in the emergency room of the Tri-County Memorial Hospital. The Respondent failed to order an x-ray examination of Patient H's back and ordered Amoxicillin in the absence of a clear medical indication.

I. On June 5, 1985, at approximately 3:15 a.m., Patient I was examined by the Respondent in the emergency room of Tri-County Memorial Hospital. Patient I had a recent history of a severe reaction to Amoxicillin. The Respondent injected Patient I with Claforan without ordering any laboratory examinations. In addition, the Respondent was rude to Patient I and implied that she should not have sought treatment in the Emergency Room.

J. On November 2, 1985, at approximately 1:30 p.m., Patient J was examined by the Respondent in the emergency room of Tri-County Memorial Hospital. The Respondent treated Patient J's upper respiratory infection with both Ampicillin and Erythromycin. The Respondent's use of two antibiotics to treat an upper respiratory infection lacked a sound medical basis.

K. On March 1, 1985, at approximately 3:15 a.m., Patient K was examined by the Respondent in the emergency room of Tri-County Memorial Hospital. Patient K had taken an overdose of Empirin with Codeine #3, Fiorinal and Motrin. The Respondent advised Patient K that there were surer ways of committing suicide than by taking drugs.

L. On November 22, 1986, at approximately 11:20 a.m., Patient L was examined by the Respondent in the emergency room of Lake Shore Hospital in Irving, New York. The Respondent failed to order a chest x-ray examination, arterial blood gases, a vital capacity test and failed to

aggressively treat this patient's asthma. Patient L was admitted fourteen hours later to WCA Hospital in Jamestown, New York with a diagnosis of acute and chronic asthma with statue asthmaticus and bilateral bronchopneumonia.

M. On June 5, 1986, at approximately 3:34 a.m., Patient M was examined by the Respondent in the emergency room of Lake Shore Hospital. The Respondent failed to examine this child's ears with an otoscope, yet the Respondent indicated in the report of his physical examination that this child's ears were unremarkable.

N. On June 14, 1987, at approximately 1:40 p.m., Patient N was examined by the Respondent in the emergency room of Buffalo. Columbus Hospital in Buffalo, New York. The Respondent failed to diagnose this patient's diabetic condition. Patient N was subsequently diagnosed as having diabetic ketoacidosis.

O. On March 29, 1987, at approximately 3:35 p.m., Patient O was examined by the Respondent in the emergency room of the Buffalo Columbus Hospital. The Respondent suggested to this female patient that she should have sex more often and get high on sex instead of drugs. The Respondent further advised this patient that should she become pregnant, it would be very easy for her to get an abortion. In addition, the Respondent advised this patient to discontinue taking INH for one month.

P. On August 9, 1987, at approximately 3:00 p.m., Patient P was examined by the Respondent in the emergency room of Buffalo Columbus Hospital. The Respondent failed to effectively address the cause for this patient's hyperventilation and exacerbated her condition by telling her that she was faking an asthma attack.

Q. On May 31, 1987, at approximately 12:55 p.m., Patient Q was examined by the Respondent in the emergency room of Buffalo Columbus Hospital. The Respondent failed to adequately rule out a diagnosis of myocardial infraction and failed to address the patient's concern that he was in cardiac distress.

R. On August 23, 1987, at approximately 11:40 p.m., Patient R was examined by the Respondent in the emergency room of Buffalo Columbus Hospital. The Respondent ridiculed this female patient for the way she dressed and told this patient that he was not giving out free narcotics.

S. On June 5, 1986, at approximately 3:10 a.m., Patient S was examined by the Respondent in the emergency room of Lake Shore Hospital. The Respondent failed to adequately rule out a diagnosis of thrombophlebitis. In addition, the Respondent ridiculed Patient S because of this patient's inability to remember the names of the medications he was taking.

T. On February 2, 1986, at approximately 5:10 p.m., Patient T was examined by the Respondent in the emergency room of Tri-County Memorial Hospital. The Respondent was rude and sarcastic toward Patient T and ridiculed this patient concerning her recollection of when she last had a tetanus shot.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION
PRACTICING WITH NEGLIGENCE AND/OR INCOMPETENCE ON MORE THAN ONE OCCASION

The Respondent is charged with practicing the profession of medicine with negligence and/or incompetence on more than one occasion under N.Y. Educ. Law Section 6509(2) (McKinney 1985), in that the Petitioner charges:

1. The facts in paragraphs: C and C.1, C.2, C.3, C.4; D; E; G; H; I; J; K; L; M; N; O; P; R and S.

SECOND SPECIFICATION
PRACTICING FRAUDULENTLY

The Respondent is charged with practicing the profession of medicine fraudulently under N.Y. Educ. Law Section 6509(2) (McKinney 1985), in that, the Petitioner charges:

2. The facts in paragraph M.

THIRD SPECIFICATION
MAINTAINING AN INACCURATE
MEDICAL RECORD

The Respondent is charged with committing unprofessional conduct under N.Y. Educ. Law Section 6509(9) (McKinney 1985) as he failed to maintain a medical record which accurately reflected his evaluation and treatment of a patient within the meaning of 8 NYCRR 29.2(A)(3) (1987), in that, the Petitioner charges:

3. The facts in paragraph M.

FOURTH SPECIFICATION
ABANDONING PROFESSIONAL EMPLOYMENT

The Respondent is charged with committing unprofessional conduct under N.Y. Educ. Law Section 6509(9) (McKinney 1985) as he abandoned professional employment at a health care facility without reasonable notice and under circumstances in which seriously impaired the delivery of professional care to patients within the meaning of 8 NYCRR 29.2(a)(1) (1987), in that, the Petitioner charges:

4. The facts in paragraph B.

FIFTH SPECIFICATION
REVEALING PATIENT INFORMATION

The Respondent is charged with committing unprofessional conduct under N.Y. Educ. Law Section 6509(9) (McKinney 1985) as he revealed personally identifiable information obtained in a professional capacity without prior consent of the patient within the meaning of 8 NYCRR 29.i(a)(8) (1984), in that, the Petitioner charges:

5. The facts in paragraph A.

SIXTH SPECIFICATION
VERBAL HARASSMENT

The Respondent is charges with committing unprofessional conduct under N.Y. Educ. Law Section 6509(a) (McKinney 1985) as he verbally harassed, abused or intimidated a patient within the meaning of 8 NYCRR 29.2(a)(2) (1987), in

that, the Petitioner charges:

6. The facts in paragraphs I, K, O, P, Q, R, S and for T.

DATED: Albany, New York
April 6, 1988

PETER D. VAN BUREN
Deputy Counsel

STATE OF NEW YORK : DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER	REPORT OF THE
OF	HEARING
DANIEL R. HODGE, M.D.	COMMITTEE

TO: HONORABLE DAVID AXELROD, M.D.
Commissioner of Health, State of New York

The undersigned Hearing Committee (the Committee) consisting of Thea Graves Pellman (Chairperson), Margaret McAloon, M.D., and William Heyden, M.D., Panel Members, was duly designated, constituted and appointed by the State Board for Professional Medial Conduct (the Petitioner). The Honorable Harry A. Allan, Esq., Administrative Law Judge served as the Administrative Officer.

The hearing was conducted pursuant to the provisions of the Public Health Law, Section 230 and Article 3 of the State Administrative Procedure Act to receive evidence concerning the charges that Respondent has violated provisions of the New York Education Law Section 6509. Witnesses were sworn or affirmed and examined. A stenographic record of the hearing was made.

The Committee has considered the entire record in the above captioned matter and makes this Report of its Findings of Fact, Conclusions and Recommendations to the New York State Commissioner of Health.

EXHIBIT "B"

AP 29

RECORD OF PROCEEDINGS

Date of Notice of Hearing:	April 6, 1988
Date of Service of Notice of Hearing and Notice of Investigative Proceeding:	April 12, 1988
Hearing noticed for:	May 26, 1988
Hearing location:	Ramada Inn 4243 Genesee Street Buffalo, New York
Dates of hearing:	May 26, 1988, June 22-28, July 18, August 24, September 2-7-13-30, October 26, December 13-21, January 13, 1989, February 17, April 21-28, May 12.
Petitioner appeared by:	Paul R. White, Esq. Associate Counsel Office for Professional Medical Conduct of Counsel to Peter J. Millock, Esq. General Counsel New York State Department of Health
Respondent appeared by:	James A. W. McLeod, Esq. 1528 Statler Towers Buffalo, New York and Daniel R. Hodge, pro se from October 26, 1988 to conclusion

Respondent's present address:	64 Marine Drive Amherst, New York
Petitioner's Post Hearing Brief Dated:	June 26, 1989
Respondent's Post Hearing Brief:	None submitted
Record Closed:	May 12, 1989
Deliberations held:	July 6 & 7, 1989

SUMMARY OF PROCEEDINGS

Daniel R. Hodge, M.D. (hereinafter "Respondent") is charged with professional misconduct under Section 6509(a)(2)(9) of the New York State in that he: (1) practiced the profession of medicine with negligence and/or incompetence on more than one occasion; (2) practiced the profession of medicine fraudulently; (3) failed to maintain an accurate medical record; (4) abandoned his professional employment; (5) revealed confidential patient information without authorization; and (6) verbally harassed, abused or intimidated patients.

The alleged misconduct involved 20 patients treated by the Respondent in various emergency room settings in the greater Buffalo area and Attica Prison.

PETITIONER CALLED THE FOLLOWING WITNESSES

	Fact Witness
1. Laura Mangani	"
2. Paul Violanti	"
3. Janine L. Dumond	"
4. Susan Mason	"

5. Susan Hill "
6. Beverly J. Smith "
7. Linda Aldinger "
8. Norman Dwarzak "
9. Betty Bates "
10. Milton Luria, M.D. Expert Witness

RESPONDENT TESTIFIED IN HIS OWN BEHALF AND CALLED:

1. Victor A. Panaro, M.D., Expert Witness

INVESTIGATIVE PROCEEDING

Concurrent with the service upon Respondent of the Notice of Hearing, there was served a Motion of Investigative Proceeding (Department's Exhibit 2). The issue to be addressed in this matter was the question of whether the Respondent was impaired by a mental disability. On July 18, 1988, based on the evidence presented to date, the Panel issued a Decision and Order directing that Respondent submit to a psychiatric examination to be conducted by James W. Bartlett, M.D. of Strong-Memorial Hospital, Rochester, New York (Department's Exhibit 49). This examination was conducted and a report dated September 13, 1988 was forwarded to the Chairperson (Panel's Exhibit 1). The report indicated there was not sufficient clinical evidence to reasonably support an Axis I diagnosis. There was a finding that the Respondent has an Axis II personality disorder of the narcissistic type. The Order also gave the Respondent the right to have a psychiatric examination by a doctor of his own choosing. He elected not to have such an examination.

FINDINGS OF FACT

1. The Respondent was licensed to practice medicine in New Your on May 12, 1978 having been issued license number 134316. The Respondent is currently registered to practice medicine from 27 A Long Meadow Road, Amherst, New York (Department's Exhibit 3).

2. The Respondent practiced as an emergency room physician in providing care to Patients A, B, C, D, E, F, G, H, I, J, K, L, M, N, O, P, Q, R, S and T (Department's Exhibits 6, 7, 13,

15, 17, 18, 21, 23, 24, 25, 26, 28, 29, 30, 31, 32, 33, 34, 35 and 55).

PATIENTS A & B

3. On or about June 2, 1987, the Respondent submitted an affidavit to the United States District Court, Western District of New York, in support of a lawsuit which the Respondent initiated against Lake Shore Hospital and other defendants (Department's Exhibit 5).

4. In this affidavit, the Respondent discussed Patient A's medical condition and treatment. The Respondent attached a copy of Patient A's emergency room chart from Lake Shore Hospital as Exhibits 5A and 5B to his publicly-filed affidavit. The Respondent described Patient A as an hysterical asthmatic who had deliberately caused herself to overbreathe. (Department's Exhibit 5).

5. Patient A was treated by the Respondent at the Lake Shore Hospital emergency room on August 27, 1986 complaining of shortness of breath, coughing, wheezing, pulse of 120 and respiratory rate of 45. (Department's Exhibits 5A & 7).

6. Patient A never consented nor authorized the Respondent to publicly disclose her medical condition and treatment and did not consent nor authorize the Respondent to attach a copy of her emergency room records to his affidavit (Department's Exhibit 7).

7. Patient B was treated by the Respondent in the Lake Shore Hospital emergency room on September 25, 1986 (Department's Exhibit 6).

8. In his publicly-filed affidavit, the Respondent discussed Patient B's history, care and treatment. The Respondent attached copies of Patient B's emergency room record and a portion of Patient B's hospital record as Exhibits 9 and 10 of the Respondent's court affidavit (Department's Exhibit 5).

9. Patient B never consented nor authorized the Respondent to publicly disclose his medical condition or treatment and neither consented to nor authorized the Respondent to attach a copy of his medical records to the Respondent's court affidavit (Department's Exhibit 6).

ABANDONING PROFESSIONAL EMPLOYMENT

10. The Respondent was employed as a Clinical Physician II at the Attica Correctional Facility in August, 1983. On March 4, 1986, the Respondent was suspended from his position at Attica because, among other things, he failed to report to work as scheduled on February 28, 1986. The Respondent's absence necessitated cancellation of his scheduled patient appointments at the health clinic. Subsequently the Respondent requested an arbitration hearing. As a result of that arbitration hearing, the Respondent was found guilty of the charges related to his failure to report to work as scheduled on February 28, 1986, resulting in a six month suspension without pay from the Attica Correctional Facility (Department's Exhibit 4 - p. 22).

11. The Respondent did not report to work at Attica as scheduled on February 6, 1987. The health clinic was canceled on that date (Department's Exhibits 11 and 12).

PATIENT C

12. Patient C, an inmate at the Attica Correctional Facility, was brought into the emergency room by gurney on March 2, 1987 at approximately 2:15 p.m. Patient C was semi-conscious, unresponsive, gasping for air, grayish in color (Transcript, Pages 737, 744, 825, 853-854; Department's Exhibit 55). According to Respondent's handwritten notes in the medical record Respondent found patient to have a "faint pulse" (Department's Exhibit 55).

13. The Respondent was the only physician working in the emergency room at Attica when Patient C arrive (Tr., Pages 736, 824).

14. Norman Dworzack, R.N., a nurse employed in the Attica emergency room, took Patient C's blood pressure and found it to be 100/70 at 2:17 p.m. (Tr., Pages 741, 825-926, 830, 833; Department's Exhibit 55).

15. Linda Aldinger, R.N., a nurse employed in the Attica emergency room, obtained an airway. An airway is used when a patient cannot breathe. The Respondent stated that he did not want to use the airway (Tr., Pages 737-738, 745, 780).

16. Nurse Aldinger placed an Ambu-bag on Patient C's face and started to use it. The Respondent told Nurse Aldinger that she was not getting a good seal and pushed the Ambu-bag away. The Ambu-bag was missing a seal which was available in the emergency room. The Respondent did not allow Nurse Aldinger a chance to obtain the proper seal and use the Ambu-bag (Tr., Pages 739-740, 752, 827 and 831).

17. The Respondent requested an endotracheal tube which was provided by Nurse Aldinger. The Respondent stated that the endotracheal tube was too large and that a stylet was required. This was not available and the Respondent did not attempt to intubate Patient C (Tr., Pages 738-739, 757, 927).

18. The Respondent requested that the electrocardiogram (EKG) be hooked up. An EKG strip was run. The Respondent looked at the EKG strip and stated it indicated the patient was in ventricular fibrillation (Tr., Pages 741-742, 828-829; Department's Exhibit 55).

19. The nursing staff started to perform cardiopulmonary resuscitation (CPR) on Patient C. The Respondent told them to stop since Patient C was dead. The Respondent himself never attempted CPR (Tr., Pages 963 and 975) (Tr., Page 2835) and pronounced Patient C dead at 2:20 p.m. (Tr., Pages 742, 831-832; Department's Exhibit 55).

20. The nursing staff at Attica were certified in CPR techniques (Tr., Pages 746, 774, 841).

21. Patient C was not in ventricular fibrillation at 2:17 p.m. since his blood pressure was 100/70 and he had a pulse. Patient C went into ventricular fibrillation between 2:17 p.m. and 2:20 p.m. (Tr., Pages 2813, 2836-2837, 2911-2912; Department's Exhibit 55).

22. The Respondent did not attempt a **precordial thump** on Patient C's chest (Tr., Pages 830-831).

23. The Respondent did not attempt to intubate Patient C with the endotracheal tube which was available. A stylet is not required to pass an endotracheal tube (Tr., Pages 716-717, 2886-2887, 2913).

24. In a **witnessed cardiac arrest** the American Heart Association standard states a **precordial thump** should be given

and CPR be initiated (Tr., Page 985.

PATIENT D

25. Patient D, an eight-year-old female, arrived at the Tri-County Memorial Hospital emergency room at 11:50 a.m. on April 20, 1986 with a history of having slipped down some steps and hit her ankle against a door (Tr., Pages 480-481; Department's Exhibit 23).

26. The Respondent, who treated Patient D in the emergency room, ordered an x-ray study of Patient D's ankle (Tr., Page 481; Department's Exhibit 23) which revealed an avulsion fracture just at the end of the fibula (Tr., Pages 481-482, 494; Department's Exhibits 23 and 43).

27. The Respondent did not diagnose the fracture, but diagnosed Patient D as having soft tissue damage to the right ankle (Tr., Pages 485, 492; Department's Exhibit 23).

PATIENT E

28. Patient E, a twenty-six year old male, arrived at the Tri-County Memorial Hospital emergency room at 4:00 p.m. on April 27, 1986 with a history of having injured his knee two hours earlier as a result of a dirt bike accident (Tr., Page 505; Department's Exhibit 24).

29. The Respondent, who treated Patient E in the emergency room, ordered x-ray's of Patient E's right knee. The x-ray films revealed that Patient E had a transverse-line fracture of his tibia (Tr., Pages 506-508; Department's Exhibits 24, 45 and 46).

30. The Respondent interpreted the x-ray films as negative for fracture. The Respondent diagnosed Patient E as having a soft tissue injury (Tr., Page 507; Department's Exhibit 24).

PATIENT F

31. Patient F, a twenty-three year-old female, arrived at the Tri-County Memorial Hospital emergency room at 1:25 a.m. on January 19, 1986 (charges mistake the date as November 19, 1986) with a history of having slipped on ice. Patient F hit her hand on a window causing swelling of the knuckle above the last

finger with acute pain and numbness (Tr., Page 513; Department's Exhibit 25).

32. The Respondent treated Patient F in the emergency room. He did not order an x-ray examination of Patient F's right hand. Based upon his physical examination, the Respondent determined that there was soft-tissue injury and no fracture (Tr., Page 514; Department's Exhibit 25).

33. There is no indication in Patient F's emergency room chart that the Respondent performed a complete physical examination of Patient F's hand (Tr., Pages 515-516 and 1010; Department's Exhibit 25). Respondent elicited pain on palpation.

34. Patient F returned to the Tri-County Memorial Hospital emergency room the following day and was seen by another emergency room physician who ordered an x-ray examination of the right hand and diagnosed Patient F as having a fracture of the right fifth metacarpal (Tr., Pages 516-517; Department's Exhibit 25).

PATIENT G

35. Patient G, a fifty-three year old female, arrived at the Tri-County Memorial Hospital emergency room at approximately 5:00 p.m. on August 16, 1986 with a history of having fallen four to five feet off a ladder landing on a cement step. Patient G developed ecchymosis of the right hip (Tr., Page 531; Department's Exhibit 26).

36. The Respondent, who treated Patient G in the emergency room, diagnosed a soft tissue injury to the right back. He prescribed an ice pack, Motrin for pain and a follow-up in a week with a private physician or clinic. The Respondent did not order any x-ray studies (Tr., Page 532; Department's Exhibit 26).

37. The Respondent's evaluation of Patient G's musculo-skeletal system consisted of palpation of right CVA area noting tenderness and skin abrasion (Tr. Pages 533-534, 542-543; Department's Exhibit 26).

38. Patient G, two days later, visited her private physician who ordered x-ray studies which revealed that Patient G had fractured four ribs as a result of her fall (Tr., Pages 536-537; Department's Exhibit 27).

39. Patient G had an open abrasion. She had not had a tetanus shot in more than ten years. The Respondent did not give patient a tetanus booster (Tr., Pages 541-542).

PATIENT H

40. Patient H, a seventy-five year old female, arrived at the Tri-County Memorial Hospital emergency room at approximately 4:00 p.m. on February 8, 1986, with a history of sharp low back pain arising from a fall one week earlier. The pain was worse when Patient H bent over (Tr., Pages 544-545; Department's Exhibit 28).

41. The Respondent, who treated Patient H in the emergency room, diagnosed low back pain and treated Patient H with Motrin and Amoxicillin. No x-ray exam or lab testing was ordered (Tr., Page 545; Department's Exhibit 28).

PATIENT I

42. Patient I, a thirty-four year old female, arrived at the Tri-County Memorial Hospital emergency room at 2:10 a.m. on June 5, 1985 with a history of a severe sore throat, earache and headache of several days duration. The patient had been treated earlier in the week with Amoxcil, which was discontinued because of her allergic reaction. She stated she had taken one dose (250 mg) of Erythromycin prior to her being seen in the E.R. (Tr., Pages 553-555; Department's Exhibits 34 and 47).

43. The Respondent, who treated Patient I in the emergency room, diagnosed the condition as acute tonsillitis/pharyngitis and injected Patient I with two grams of Claforan (Tr., Pages 554-555; Department's Exhibit 34).

44. The Respondent did not obtain a throat culture to attempt to specifically identify the infectious organism which was present (Tr., Pages 555-558).

45. Respondent told Patient I before examining her that she was not sick and should not have come to the hospital (Tr., Pages 298-300, 315, 318; Department's Exhibit 36).

PATIENT J

46. Patient J, a forty-seven year old female, arrived at the Tri-County Memorial Hospital emergency room at 1:20 p.m. on November 2, 1985 with a history of severe vertigo, nausea, sore throat and malaise (Tr., Page 616; Department's Exhibit 29).

47. The Respondent, who treated Patient J in the emergency room, diagnosed an upper respiratory infection and a hard palate infection. No cultures were taken. The Respondent prescribed Erythromycin and Ampicillin to be taken concurrently for seven days (Tr., Pages 616-617; Department's Exhibit 29).

PATIENT K

48. Patient K, a twenty-one year old female, arrived at the Tri-County Memorial Hospital emergency room at 2:45 a.m. on March 1, 1985 with a history of having consumed twenty tables to Empirin with codeine, some Fiorinal with codeine and alcohol (Tr., Pages 355, 622; Department's Exhibit 35 - p. 3).

49. The Respondent told Patient K that taking pills was not the surest way to commit suicide, and the if she wanted to commit suicide there were better ways than by taking pills (Tr., Pages 356, 361-362).

PATIENT L

50. Patient L, a fifty-one year old female, arrived in the Lake Shore Hospital emergency room at 11:15 a.m. on November 22, 1986 with a history of asthma, flushed face, congestion, chills, wheezing and a cough productive of purulent sputum (Department's Exhibit 30). The Respondent evaluated Patient L in the emergency room, diagnosed bronchitis and asthma. He prescribed Amoxicillin and had her continue Tylenol and Theo-dur which she had been taking prior to being seen in the E.R. (Tr., Page 629; Department's Exhibit 30).

51. The Respondent did not obtain an adequate medical history from Patient L (Tr., Page 629; Department's Exhibit 30). Patient L had a long history of severe asthma with multiple hospitalizations. She had been hospitalized nine months earlier for status asthmaticus and viral bronchitis (Tr., Page 641; Department's Exhibit 48).

52. The Respondent did not order a chest x-ray or arterial blood gas test, and did not diagnose Patient L's bronchopneumonia (Tr., Pages 632-634, 636, 639, 1600, 1946 and 1957).

53. Patient L was discharged from the Lake Shore Hospital emergency room within thirty minutes of her arrival. She had received no treatment in the E.R. (Tr., Page 644; Department's Exhibit 30).

54. Within fourteen hours of her discharge from the Lake Shore Hospital emergency room, Patient L was seen by a different physician at the WCA Hospital emergency room. The subsequent emergency room physician treating this patient ordered a chest x-ray. A diagnosis of bilateral bronchopneumonia and acute and chronic asthma was made by physicians at this hospital (Department's Exhibit 48 - pages 3 and 4).

PATIENT M

55. Patient M, a boy who was one year and nine months old, arrived at the Lake Shore Hospital emergency room with his parents at approximately 3:30 a.m. on June 5, 1986. Patient M had a history of convulsions and elevated temperature (Tr., Page 644; Department's Exhibit 31).

56. The Respondent, who treated Patient M in the emergency room, diagnosed a febrile seizure/questionable bronchiolitis, upper respiratory tract infection (Department's Exhibit 31).

57. The Respondent reported on Patient M's emergency room record that the HEENT, i.e., head, ear, eyes, nose and throat, were unremarkable. There was no exam of patient's ear using an otoscope (Tr., Pages 580-581, 647 and 687; Department's Exhibits 31 and 53).

58. This statement on the medical record was false as the Respondent never examine Patient M's ear, with or without an otoscope (Tr., Page 580-581; Department's Exhibit 53).

59. The Respondent did not examine Patient M's throat, nor did the Respondent listen to the front of Patient M's chest or examine Patient M's abdomen. Furthermore, a neurological

examination was not performed (Tr., Pages 587-589; Department's Exhibit 53).

60. Patient M did not cry during the examination or in any way hinder or prevent the Respondent from performing a complete examination (Tr., Page 584).

PATIENT N

61. Patient N, a twenty-one year old male, arrived at the Buffalo Columbus Hospital emergency room at 1:20 p.m. on June 14, 1987 with a history of drug abuse, hot flashes, needing cold showers to cool off, a dry tongue, dizziness, rapid loss of weight, weakness and **an infected cyst** on his back which was not healing (Tr., Pages 50, 52, 56, 85, 652-653; Department's Exhibit 13 - p.1).

62. The Respondent, who treated Patient N in the emergency room prescribe Amoxicillin, Betadine for the lesion, and a follow-up with a surgeon for incision and drainage of the lesion. The Respondent's diagnosis was bronchitis, abscess and drug abuse (Tr., Page 65; Department's Exhibit 13 - p. 1).

63. The Respondent never touched Patient N during the physical examination, i.e., the Respondent never physically laid hands upon Patient N nor did Respondent order x-rays or lab tests (Tr., Pages 59-60, 62, 85, 91, 118; Department's Exhibits 13 and 14).

64. The Respondent did not examine Patient N with a stethoscope, listen to Patient N's heart, feel Patient N's wrist, touch Patient N's abdomen, touch the area of Patient N's abscess, examine Patient N with a neurological hammer nor did he check Patient N's cranial nerves (Tr., Pages 107-109). However, on the E.R. sheet the Respondent wrote down findings which could only be decided by a hands-on physical examination (Department's Exhibit 13).

65. Respondent failed to take an adequate medical history which would have shown that Patient N had a strong family history of diabetes (Tr., Pages 58, 130-131; Department's Exhibits 13 and 14).

66. Patient N subsequently returned to the Buffalo Columbus Hospital emergency room the next day, June 15, 1987,

and was seen by a different physician. The subsequent emergency room physician treating this patient obtained a family history of diabetes, performed a physical exam and ordered appropriate lab tests. The subsequent emergency room physician treating this patient diagnosed diabetic ketoacidosis (Tr., Page 652; Department's Exhibit 13 - p. 6).

67. The history and symptoms exhibited by Patient N were consistent with a diagnosis of uncontrolled diabetes mellitus (Tr., Pages 82-83, 658).

PATIENT O

68. Patient O, a twenty-five year old female, arrived at the Buffalo Columbus Hospital emergency room at 3:00 p.m. on March 29, 1987 with complaints of flashbacks from an old accident. Patient O was being treated with INH because of a positive tuberculosis test. In addition, the patient admitted to current drug abuse including the use of hallucinogenic drugs (Tr., Pages 166-167, 190; Department's Exhibit 17).

69. The Respondent, who treated Patient O in the emergency room, advised Patient O to discontinue taking INH for one month, to stop abusing marijuana and other drugs and to follow up with a private physician or clinic (Tr., Page 170; Department's Exhibit 17).

PATIENT P

70. Patient P, a twenty-four year old female, came to the Buffalo Columbus Hospital at approximately 2:50 p.m. on August 9, 1987 with a history of asthma, bilateral wheezing, upper respiratory congestion and a respiratory rate of forty (Tr., Pages 214, 243-244, 675; Department's Exhibit 18).

71. The Respondent diagnosed Patient P as hysterical and having uncompensated respiratory alkalosis (Tr., Page 676; Department's Exhibit 18).

72. The Respondent accused Patient P of faking her asthmatic attack, stating that she must have just had a fight with her boyfriend. The Respondent told Patient P that she came to the hospital to get sympathy and that the Respondent would not give her any medicine (Tr., Pages 216, 218).

73. Patient P became very upset and hysterical following the Respondent's accusations. It took approximately one hour [sic] calm her down and get her to stop crying and vomiting. Patient P left the hospital only after using her asthma medication (Tr., Page 219; Department's Exhibit 19).

74. Patient P's blood gas analysis indicated that she had fully-compensated respiratory alkalosis while receiving two liters of nasal oxygen. The patient's blood gas analysis was inconsistent with the Respondent's diagnosis of an uncompensated respiratory alkalosis and hysteria. **Patient P's blood gas analysis indicated that respiratory insufficiency had been present for some time (Tr., Pages 680-681).**

PATIENT Q

75. Patient Q, a forty-five year old male, arrived at Buffalo Columbus Hospital emergency room at 12:10 p.m. on May 31, 1987 with a history of having awoken with left mid-chest pain, left-sided numbness and swelling (Tr., Pages 133-134; Department's Exhibit 15).

76. On arrival at the emergency room, Patient Q was upset and concerned that he might be having a heart attack.

77. The Respondent, who treated Patient Q in the emergency room, diagnosed a temporary neurological sensitivity defect and discharged the patient prior to obtaining the results of the cardia enzyme study (Tr., Page 690; Department's Exhibit 15).

78. The cardiac enzyme study, which was performed and was available the next day, indicated that the patient had myocardial damage consistent with a diagnosis of myocardial infarction (Tr., Pages 693-696).

79. Patient Q should have been kept at the hospital until such time as the results of the test were available. The Respondent did not adequately rule out a diagnosis of myocardial infarction (Tr. Pages 695-696).

PATIENT R

80. Patient R, a thirty-eight year old female, arrived at the Buffalo Columbus Hospital emergency room at approximately

11:20 p.m. on August 23, 1987 with a history of migraine headache and shoulder pain (Tr., Pages 804-805; Department's Exhibit 32).

81. The Respondent, who treated Patient R in the emergency room, diagnosed tension headaches and suggested that Patient R take a non-steroidal anti-inflammatory drug (Department's Exhibit 32).

82. The Respondent did not look at Patient R's eyes, did not use a reflex hammer, nor examine nor palpate Patient R's neck or head in anyway (Tr., Pages 820-821).

83. The Respondent commented on the manner in which Patient R was dressed; he told Patient R that she did not work and suggested that Patient R was a prostitute who was looking for a Sunday-morning high with free narcotics (Tr., Pages 805-808, 914). Patient went home and got her military discharge papers to prove she had been in the Army.

PATIENT S

84. Patient S, a fifty-eight year old male, arrived at the Lake Shore Hospital emergency room at 3:04 a.m. on June 5, 1986 with a complaint of left leg cramping for five hours which was progressively getting worse. The patient had been lying in bed on his back for the past week (Tr., Pages 592-593, 699; Department's Exhibit 33).

85. Respondent performed an exam on patient's lower extremities (Tr., Pages 606-609; Department's Exhibit 33).

86. Patient S could not remember the name of the anti-inflammatory drug and muscle relaxant which he was taking. When patient could not remember the name of this medicine, Dr. Hodge (the Respondent) instructed him to tell him how many fingers he was holding up (Tr., Page 594; Department's Exhibit 33).

PATIENT T

87. Patient T, a thirty-three year old female, arrived at the Tri-County Memorial Hospital emergency room at approximately 5:00 a.m. on February 2, 1986 with a complaint of having been bitten on the hand while breaking up a dog fight

(Tr., Pages 259-261; Department's Exhibit 21).

FACTUAL DISCUSSION

PATIENTS A & B

A patient is entitled to confidentiality of his/her medical records and treatment unless disclosure is explicitly authorized or confidentiality is deemed to be waived by virtue of the patient's conduct. Patients A and B have done nothing to waive their confidentiality by word or action. Therefore the Respondent's discussion of the medical condition and treatment of Patients A and B in a publicly-filed affidavit and the Respondent's disclosure of their medical records without legal justification was an act of unprofessional conduct.

ABANDONING PROFESSIONAL EMPLOYMENT

The Respondent denied that he was late for work at the Attica Correctional Facility medical clinic on February 28, 1986 and February 6, 1987 (Tr., Pages 920-921).

The Respondent's denial of his lateness of February 28, 1986 must be rejected on legal grounds. The Respondent had already unsuccessfully litigated this issue in a arbitration with the Attica Correctional Facility (Finding of Fact 10). It is well settled that the legal doctrine of collateral estoppel precludes an individual from relitigating an issue which was decided adversely in a different administrative forum. Willer v. Board of Regents, 101 AD2d 937 (Third Dept., 1984).

The Respondent testified that he was late for work on February 6, 1987 because his plane flight from New York City was delayed by two hours (Tr., Pages 935-936). However, according to the travel voucher which the Respondent submitted he returned to Buffalo at 10:00 p.m. on February 6, 1987 (Respondent's Exhibit I - p. 5). Since the Respondent was scheduled to work from 9:00 a.m. to 6:00 p.m. on February 6, 1987 (Department's Exhibit 12), the Respondent was more than two hours late. Therefore, this charge is sustained.

PATIENT C

The Respondent testified that since the Attica Correctional Facility did not have a defibrillator among its emergency medical equipment there was nothing that could be done for Patient C (Tr., Pages 957-965). The Respondent also testified that the nursing staff in attendance in the Attica emergency room were not trained in CPR (Tr., Pages 936-964) and that Patient C's cardiac arrest occurred prior to the patient's arrival in the emergency room (Tr., Page 966).

The Respondent's testimony about the nursing staff's lack of CPR training was false. All members of the Attica nursing staff were trained in CPR techniques and recertified on an annual basis (Findings of Fact 25). Furthermore the Respondent was incorrect about the timing of Patient C's cardiac arrest. Patient C arrived in the emergency room at 2:15 p.m. in a semi-conscious, unresponsive condition, gasping for air and grayish in color with a faint pulse and a blood pressure of 100/70 (Finding of Fact 14). The Respondent himself, according to his own handwritten progress notes, found that Patient C had a faint pulse when the patient arrived in the emergency room (Finding of Fact 27). Patient C developed ventricular fibrillation between 2:17 p.m. and 2:20 p.m. (Finding of Fact 21). Patient C could not have been in ventricular fibrillation when he arrived in the emergency room as the Respondent would not have been able to obtain a pulse and the nurse would not have been able to obtain a blood pressure reading (Findings of Fact 21).

Patient C had a **witnessed cardiac arrest.** The Respondent never attempted a **precordial thump** on Patient C's chest, never attempted to intubate the Patient, never attempted to use an airway, did not allow the nursing staff to attempt to fix and use the Ambu-bag, did not allow the nursing staff to perform CPR and did not attempt CPR himself. The Respondent pronounced Patient C dead at 2:20 p.m., thereby depriving Patient C of any chance to survive. This constitutes negligence on the part of the Respondent.

PATIENT D

While Respondent did not interpret the x-rays of Patient D's right ankle to indicate an avulsion fracture of the tip of the distal fibula, testimony was offered by Dr. Victor Panaro (Tr., Page 1511, lines 18-24) and Dr. Milton Luria (Tr., Page 499) that fractures of this type are frequently overlooked by a non-radiologist. Therefore, this charge is not sustained.

PATIENT E

While Respondent did not interpret the x-rays of Patient E to indicate a fracture of the right proximal tibia, testimony was offered by Dr. Victor Panaro (Tr., Page 1533, line 15-17) that fractures of this type are frequently overlooked by a non-radiologist and that Respondent cannot be held to the same standards as a radiologist. Therefore, this charge is not sustained. However, it should be noted that Dr. Hodge's knowledge of a clinical presentation of fractures is inadequate.

PATIENT F

Respondent failed to perform an adequate physical examination and evaluation of the swelling to the knuckle of the last finger on the right hand of Patient F and failed to order an x-ray examination (Tr., Pages 515-516; Department's Exhibit 25; Tr., Page 1010). Respondent was negligent in his care of Patient F in that he failed to order an x-ray examination. Therefore, this charge is sustained.

PATIENT G

Given the presenting history of Patient G of a fall of 4 to 5 feet onto a concrete step and the physical findings of tenderness in the right hip and the CVA angle, plus skin abrasions in these areas and ecchymosis upon examination by the Respondent, an x-ray study should have been ordered. (Tr., Pages 533, 534, 537). Respondent's failure to do so constituted negligence. Charges are sustained.

PATIENT H

Respondent failed to order an x-ray examination of Patient H's back although one was indicated by patient's history of low back pain following a fall (Findings of Fact No. 40, Tr., Pages 544-546). A review of the Emergency Room record of Patient H indicated that an adequate physical examination was not performed on Patient H (Department's Exhibit 28; Tr., Pages 548, 550). Also, there is no medical indication for the use of an antibiotic (Department's Exhibit 28; Tr., Page 546). Respondent also indicated that he was uncertain as to why he ordered Amoxicillin for this patient (Tr., Page 1085). This constitutes negligent treatment and therefore all charges are sustained.

PATIENT I

Despite Patient I's recent history of a reaction to Amoxicillin (Department's Exhibits 34, 47), Respondent injected Patient I with a single dose of Claforan. The use of Claforan was inappropriate for the following reasons: Patient had received an inadequate trial of Erythromycin, a single dose of Claforan with a half-life of 2-3 hours is not indicated in the treatment of any infection, and Claforan may cause an allergic reaction in individuals with sensitivity to drugs in the Penicillin family. When Patient I had not responded to antibiotic therapy of five-days' duration, a throat culture should have been obtained prior to any change in therapy. Therefore, the charge relative to Patient I's antibiotic therapy sustained.

As to the charge of verbal harassment of Patient I, Patient I, in her testimony, was unable to give any direct quote from the Respondent's alleged verbal harassment (Tr., Page 298, lines 25-29). The letter written by Patient I complaining of verbal abuse by Respondent was undated and not specific (Department's Exhibit 36). Questions by a panel member elicited that the letter could have been written as long as several days or even weeks later and contained comments in conversations with Patient I's customers that appeared to have been initiated by Patient I after June 5, 1987. Also, Susan Nehring Hill, one of the nurses who was present in the Emergency Room that night, testified she did not recall Patient I's conversation with Dr. Hodge as testified to

by Patient I (Tr., Pages 391-393).

PATIENT J

Respondent's use of two antibiotics in the treatment of Patient J's upper respiratory infection lacked a sound medical base. The history obtained and physical examination conducted on this patient by Respondent (Department's Exhibit 29) did not support Respondent's contention that multiple infections could have been causing her sore throat. If the Respondent suspected multiple or unusual infections, then a throat culture should have been obtained. With Respondent's diagnosis of an upper respiratory infection, the use of even one antibiotic is questionable; the use of two antibiotics is clearly contraindicated. Therefore, Respondent's treatment of this patient was incompetent. Charges are sustained.

PATIENT K

Respondent claimed that he was merely counseling Patient K and Patient K's husband when he said that there were surer ways to commit suicide than by taking pills. (Tr., Pages 1146, 1159). Testimony by Nurse Susan Nehring Hill does not contradict Respondent's claim that he was counseling Patient K (Tr., Page 367). Charges that Respondent was negligent in the treatment of Patient K and that Respondent verbally harassed Patient K were not proven conclusively.

PATIENT L

Respondent's treatment of Patient L's asthma should have been more aggressive because of her audible wheezing, purulent sputum, temperature of 102.3 and her history of multiple hospitalizations associated with her asthma (Department's Exhibit 30; Tr., Pages 630-34, 641).

A chest x-ray should have been ordered and an assessment of her respiratory status, i.e. arterial blood gases or peak flow (Tr., Pages 632-34, 1600) should have been obtained.

Respondent provided no treatment to this patient in the Emergency Room except for Tylenol and Amoxicillin (Department's Exhibit 30) given to her in the Emergency Room.

Even Respondent's expert witness agreed that a chest x-ray was indicated in an asthmatic who presented with signs of a pulmonary infection (Tr., Page 1600). Respondent's care of Patient L was negligent and incompetent and the charge is sustained.

PATIENT M

Respondent is charged with failure to examine Patient M's ears. Patient M had presented in the Emergency Room with a temperature of 103.6 and a history of seizure, presumed to be of febrile origin (Department's Exhibit 31). Given this information, a complete physical examination, including an examination of the ears with an otoscope, should have been performed. Respondent did not conduct such an examination (Tr., Page 581). Although Respondent indicated in the Emergency Room record (Department's Exhibit 31) "HEENT ' unremarkable" he had not, in fact, conducted such an examination (Tr., Page 1217). Even after the patient's temperature had returned to normal, Respondent still did not examine the patient's ears (Tr., Page 1228, line 19-23). Therefore, this constitutes negligence by the Respondent in the case of Patient M, fraudulent practice and maintaining an inaccurate medical record. Therefore, all charges are sustained.

PATIENT N

Respondent failed to diagnose Patient N's diabetic condition and defended his failure on the grounds that the Patient's symptoms and complaints were suggestive of current drug abuse (Tr., Pages 1231, 1233). In point of fact, Patient N denied recent drug usage, stating that his last use of cocaine was three months prior (Department's Exhibit 13A).

Respondent's failure to perform a "hands-on" examination of this patient was inexcusable and probably contributed to his misdiagnosis (Department's Exhibit 14). Respondent claimed his differential diagnosis for Patient N included diabetes, yet he did not order a non-invasive, readily-available and inexpensive urine sugar test (Tr., Pages 1243-1245). Therefore, this constitutes negligent practice on the part of Respondent and this charge is

sustained.

In addition, it should be noted that the Respondent's written record on the Patient's Emergency Room sheet indicated that a physical examination had been performed, when, in fact, it had not.

PATIENT O

Respondent was charged with advising Patient O to replace drugs with sex, to go out and have all the sex she wanted and if Patient O were to become pregnant, then that could be handled. These charges were based on the testimony of Nurse Paul Violanti (Tr., Pages 168-169) and on Nurse Violanti's Early Warning Report (EWR) following the incident (Department's Exhibit 20).

Respondent contended these comments made by him to this Patient were in the context of counseling her and were misunderstood by Nurse Violanti (Tr., Pages 1264-1265). Patient O never testified. Therefore, these charges are not sustained.

Respondent discontinued Patient O's INH because of his concern that her flashbacks were a side effect of that medicine (Tr., Page 2191, lines 9-16, pp 2201, 2202), and, accordingly, it was appropriate for the medication to be discontinued. The charges, therefore, are not sustained.

PATIENT P

The Respondent admitted that he told Patient P that she was faking an asthma attack (Tr. Pages 1290-1291, 1298). The Respondent stated that he was able to tell, simply by looking at Patient P, and without benefit of any physical examination or history, that Patient P was faking her asthma attack (Tr., Pages 1291-1293, 1295-1297). Respondent testified that he did not need to obtain a history from Patient P in order to know that an emotional conflict was the cause of this patient's hyperventilation (Tr., Pages 1302, 1305-1306).

Respondent was wrong about this patient faking her asthma attack. Given this patient's history and presentation, and the results of arterial blood gas analysis it was unreasonable for Respondent to conclude that Patient P was faking an asthma

attack (Findings of Fact 74). Furthermore, even if the Respondent were correct in this assessment, his verbal confrontation with this patient could only have served to heighten the patient's hysterical condition. Not surprisingly, Respondent's confrontation with Patient P did, in fact cause this patient to become more upset and hysterical (Findings of Fact 72 and 73).

During Respondent's cross-examination of Dr. Luria, Respondent quoted from a medical textbook on the subject of a physician's proper approach to an asthmatic patient:

> A patient's emotional state has a bearing on the response to therapy, however, this finding can be used to advantage by the effective clinician who takes a confident, calm, reassuring approach to the patient, especially during acute attacks (Tr., Page 2312).

Respondent was not calm or reassuring in his dealings with Patient P. Respondent's care of Patient P was negligent and incompetent. His comments constituted verbal harassment. Charges are sustained.

PATIENT Q

Respondent failed to adequately rule out a diagnosis of myocardial infarction in Patient Q prior to discharging him from the Emergency Room (Tr., Pages 695-696; Department's Exhibit 15). Respondent had obviously considered the possibility that Patient Q was having a myocardial infarction because he ordered an EKG and set of cardiac enzymes (Department's Exhibit 15). The EKG was normal, but the results of the cardiac were not available until the next day. Instead of admitting Patient Q to the hospital for cardiac observation, Respondent discharged Patient Q from the Emergency Room with a diagnosis of temporary neurological sensitivity defect (Department's Exhibit 15). In light of Patient Q's complaints, he should have been admitted to the hospital until the result of his enzyme studies were known (Tr., Pages 694-695). This represented negligence on the part of Respondent in the case of Patient Q and the charge is hereby sustained.

Nurse Mangani's testimony that Respondent was rude and sarcastic towards Patient Q and his wife was mitigated by her testimony as to Patient Q's wife's behavior (Tr., Pages 137-139). Therefore, this charge is not sustained.

PATIENT R

Respondent is charged with ridiculing Patient R and telling her he was not giving out fee narcotics. Patient R testified in a straightforward manner that she did not ask for specific medications and that she did not ask for narcotics. In addition, she testified Respondent ridiculed her by asking her insulting and demeaning questions about her dress and her work. (Tr., Pages 804, 805, 820). Charges of verbal harassment are therefore sustained.

PATIENT S

The charge that Respondent failed to adequately rule out a diagnosis of thrombophlebitis has not been proved. Respondent performed an adequate examination of patient's lower extremities (Department's Exhibit 33; Tr., Pages 606, 609). Given the findings of Respondent's physical examination, a venogram or further specialized tests were not necessarily indicated.

While Respondent's gesture and comments to Patient S were inappropriate and unprofessional, they did not constitute verbal harassment.

PATIENT T

Respondent was charged with being rude and sarcastic to Patient T and ridiculing her on her recollection of when she had had her last tetanus shot. Although Patient T testified that Respondent's comments were sarcastic and rude and thus were inappropriate, they still did not rise to the level of verbal abuse and harassment. Consequently, charges are not sustained.

SUMMARY OF CONCLUSION

First Specification
Practicing with Negligence and/or Incompetence on more than one occasion.

The Hearing Committee, unanimously by a vote of 3-0, concludes that Respondent is guilty of negligence and/or incompetence in his treatment of Patients A, B, C, F, G, H, I, J, L, M, N, P, Q and R.

Second Specification
Practicing Fraudulently.

The Hearing Committee, unanimously by a vote of 3-0, concludes that Respondent practiced the profession of medicine fraudulently in his treatment of Patient M.

Third Specification
Maintaining an Inaccurate Medical Record.

The Hearing Committee, unanimously by a vote of 3-0, concludes that Respondent maintained an inaccurate record of his treatment of Patient M.

Fourth Specification
Abandonment of Employment

The Hearing Committee, unanimously by a vote of 3-0 concludes that Respondent abandoned his professional employment at Attica Prison.

Fifth Specification
Revealing Patient Information.

The Hearing Committee, unanimously by a vote of 3-0 concludes that Respondent revealed patient information without authorization regarding Patients A and B.

Sixth Specification
Verbal Harassment.

The Hearing Committee, unanimously by a vote of 3-0, concludes that Respondent verbally harassed the following

Patients: P and R.

CONCLUSIONS

Several very disturbing patterns emerged from the proof in this case. It must be concluded that, on repeated occasions, the Respondent refused to utilize readily-available diagnostic modalities, e.g., radiographic studies or laboratory evaluations, to confirm or rule out a diagnosis. During his testimony in many of these cases, Respondent frequently referred to his abilities to make diagnoses based on what he sees "with his two eyes" and that he did not have to rely on additional information. It is likely that the Respondent's unjustified and unreasonable confidence in his clinical diagnostic skills is an out-growth of his narcissistic personality disorder, which manifests itself in blind confidence in his own abilities (Committee's Exhibit 1).

The Respondent's failure to use available diagnostic modalities had the following detrimental effects on patients: the fractures of Patients F and G went undetected; the cause of Patient H's back pain went unexplored; the organism responsible for Patient I's infection remained unknown; Patient L's bronchopneumonia went undetected; Patient N's diabetic ketoacidosis went undiagnosed; Patient Q's myocardial infarction was not diagnosed and CPR was never instituted on Patient C. In addition to the above, the Respondent unjustifiably concluded that Patients A and P were faking their asthma attacks. What makes the Respondent's negligence all the more striking is that all of these cases of misdiagnosis occurred within a two-year time period.

The Respondent's negligence and incompetence was not limited to his failures in diagnosis. The Respondent's treatment of many of these patients fell below acceptable medical standards. Patient E should have been given crutches, Patient G should have been given a tetanus shot, Patient H was treated with an antibiotic without indication, Patient I was injected with an antibiotic which could have caused an allergic reaction, Patient J was inappropriately treated with two antibiotics simultaneously, Patient L's asthma was under treated, Patients A and P's respiratory distress was exacerbated and Patient T was

unnecessarily given a tetanus shot. Perhaps most disturbing was that the Respondent pronounced Patient C dead before even the most basic life-support measures were offered. The nursing staff at the Attica Correctional Facility was ready and willing to attempt to save Patient C's life, only to be frustrated and stymied by the Respondent. The Respondent failed to treat Patient C's **witnessed cardiac arrest** with a **precordial thump,** failed to attempt to intubate Patient C, failed to allow the nurses to fix and use the Ambu-bag to ventilate Patient C and stopped the nursing staff from performing CPR. The Respondent's abandonment of Patient C in the face of this patient's critical medical condition is made all the more disturbing because the Respondent purportedly specialized in emergency medicine.

Another disturbing pattern to emerge from the proof was the Respondent's repeated failure to perform an adequate physical examination and obtain a careful medical history. The Respondent failed to perform a careful physical examination of Patient F's hand, did not perform a thorough evaluation of Patient G's musculoskeletal system nor obtain a careful history from this patient, failed to perform an adequate physical examination of Patient H's back, ignored Patient J's complaints of severe vertigo, failed to obtain a medical history related to Patient L's history of asthma, failed to examine Patient M's throat, ears, abdomen or perform a neurological examination on this child, failed to physically touch Patient N during his physical examination and failed to obtain a family history related to diabetes and failed to perform a neurological examination in response to Patient R's headache complaints. It is not surprising that the Respondent's diagnosis and treatment of these patients was so awry in light of the poor quality of his histories and physical examinations.

The Respondent's proclivity to prejudge and stereotype patients also became evident in this case. Instead of dealing with patients as individuals and their complaints as genuine, the Respondent would unreasonably conclude that patients were faking their complaints in order to obtain drugs or sympathy. The Respondent accused Patient A of deliberately causing herself to overbreathe, told Patient I, prior to examining this patient,

that she was not sick and should not have come to the hospital, presumed that Patient J was mischaracterizing her complaints as vertigo, presumed that Patient L's asthma was not an immediate medical problem, presumed that Patient N was just another drug abuser who was lying about his recent drug usage, accused Patient P of faking an asthmatic attack to gain sympathy, suggested that Patient R's headache complaints were not genuine and that this patient was a prostitute looking for a free high, and presumed that Patient S came to the emergency room seeking narcotic drugs. The Respondent was in error in arriving at many of his conclusions concerning these eight patients. The Respondent's habit of stereotyping individuals also affected his judgment concerning Patient C in that he incorrectly presumed that this patient suffered from AIDS. The Respondent testified that CPR was withheld from Patient C because of this unsubstantiated concern for AIDS.

Another striking feature which emerged from the proof was the pattern of inappropriate and unprofessional comments on the Respondent which frequently escalated into verbal harassment and abuse. This practice is particularly disturbing in light of the vulnerability of an emergency room patient. It is generally the case that emergency room patients are in pain or anxious about the immediate medical problem which has caused them to seek treatment. Furthermore the emergency room patients could not turn elsewhere for treatment as the Respondent was the only physician on duty at the time. The fact that the Respondent's inappropriate and unprofessional comments were directed to such a vulnerable patient population makes it particularly reprehensible.

Pursuant to an Order of the Panel, the Respondent submitted to a psychiatric examination and evaluation. It was the opinion of the examining psychiatrist that Respondent has a personality disorder of narcissistic type (Panel's Exhibit 1). Panel's observations of the Respondent during 16 days of hearing support this diagnosis. The Respondent's narcissistic personality disorder interfered with his care of patients in that he relied on an exaggerated sense of his own abilities resulting in his not ordering simple auxiliary laboratory and x-ray tests and

performing adequate physical examinations, all of which resulted in Respondent reaching premature conclusions and misdiagnoses.

Throughout the hearing, Respondent claimed that the hearing was part of a racial conspiracy against him. This is shown in great detail by the following exhibits: (Department's Exhibits 8, 9, 10, 51, 60, 62 and Panel's Exhibit 2). The Respondent offered no proof nor called any witnesses to substantiate this claim and the Panel found no evidence to support the Respondent's allegation of racial conspiracy.

RECOMMENDATIONS

Based on the entire record herein it is the unanimous by a vote of (3-0) recommendation of the Hearing Committee that the Respondent's license to practice medicine in the State of New York be revoked.

DATED: August 23, 1989

Respectfully submitted,

Thea Graves Pellman
Chairperson
William Heyden, M.D.
Margaret McAloon, M.D.

STATE OF NEW YORK : DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER

OF

COMMISSIONER'S RECOMMENDATION

DANIEL R. HODGE, M.D.

TO: Board of Regents
New York State Education Department
State Education Building
Albany, New York

A hearing in the above-entitled proceeding was held on May 26, June 22, 28, July 18, August 24, September 2, 7, 13, 30, October 26, December 13, 21, 1988, January 13, February 17, April 4, 21, 28, May 12, 1989. Respondent, Daniel R. Hodge, M.D., appeared by James A. W. McLeod, Esq., and pro se from October 26, 1988 to conclusion. The evidence in support of the charges against the Respondent was presented by Paul R. White, Esq.

NOW, on reading and filing the transcript of the hearing, the exhibits and other evidence, and the findings, conclusions and recommendation of the Committee,

I hereby make the following recommendation to the Board of Regents:

A. The Findings of Fact and Conclusions of the Committee should be accepted in full except that I would delete the reference to Patients A and B in the Summary of Conclusions regarding the First Specification (Report of the Hearing Committee, p. 36);

B. The Recommendation of the Committee should be accepted; and

C. The Board of Regents should issue an orde. adopting and incorporating the Findings of Fact and Conclusions and further adopting as its determination the Recommendation described above.

The entire record of the within proceeding is transmitted with this Recommendation.

DATED: Albany, New York
November 6, 1989

David Axelrod, M.D.
Commissioner of Health
State of New York

AP 60

EXHIBIT "D"

TERMS OF PROBATION
OF THE REGENTS REVIEW COMMITTEE

DANIEL R. HODGE

CALENDAR NO. 10444

1. That respondent shall make quarterly visits to an employee of and selected by the Office of Professional Medical Conduct of the New York State Department of Health, unless said employee agrees otherwise as to said visits, for the purpose of determining whether respondent is in compliance with the following:

   a. That respondent, during the period of probation, shall act in all ways in a manner befitting respondent's professional status, and shall conform fully to the moral and professional standards of conduct imposed by law and by respondent's profession;

   b. That within the first month, the sixth month, and every six months thereafter, during respondent's probation, respondent shall submit to an examination, at respondent's expense, by a psychiatrist chosen by respondent and previously approved, in writing, by said employee, and respondent shall supply, within the first month of probation, the sixth month, and every six months thereafter, a written report from said psychiatrist, said report to state whether or not respondent is fit to practice as a physician in the State of New York; that respondent must be fit to practice as a physician in the State of New York in order to be in compliance with this term of probation, such

fitness to be demonstrated by said report from the psychiatrist; and that if information is received by the New York State Department of Health, from said psychiatrist indicating that respondent is unfit to practice respondent's profession, such information shall be processed to the Board of Regents for its determination in a violation of probation proceeding initiated by the New York State Department of Health and/or such other proceedings pursuant to the Public Health Law, Education Law, and/or Rules of the Board of Regents;

c. That respondent shall submit written notification to the New York State Department of Health, addressed to the Director, Office of Professional Medical Conduct, Empire State Plaza, Albany, NY 12234 of any employment and/or practice, respondent's residence, telephone number, or mailing address within or without the State of New York;

d. That respondent shall submit written proof from the Division of Professional Licensing Services (DPLS), New York State Education Department (NYSED), that respondent has paid all registration fees due and owing to the NYSED and respondent shall cooperate with and submit whatever papers are requested by DPLS in regard to said registration fees, said proof from DPLS to be submitted by respondent to the New York State Department of Health, addressed to the Director, Office of Professional Medical Conduct, as aforesaid, no later than the first three months of the period of probation; and

e. That respondent shall submit written proof to the New York State Department of Health, addressed

to the Director, Office of Professional Medical Conduct, as aforesaid, that 1) respondent is currently registered with the NYSED, unless respondent submits written proof to the New York State Department of Health, that respondent has advised DPLS, NYSED, that respondent is not engaging in the practice of respondent's profession in the State of New York and does not desire to register, and that 2) respondent has paid any fines which may have previously been imposed upon respondent by the Board of Regents; said proof of the above to be submitted no later than the first two months of the period of probation;

2. If the Director of the Office of Professional Medical Conduct determines that respondent may have violated probation, the Department of Health may initiate a violation of probation proceeding and/or such other proceedings pursuant to the Public Health Law, Education Law, and/or Rules of the Board of Regents.

STATE OF NEW YORK : DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER	NOTICE
OF	OF
DANIEL R. HODGE, M.D.	INVESTIGATIVE
	PROCEEDING

TO: DANIEL R. HODGE
64 Marine Drive
North Tonawanda, New York

PLEASE TAKE NOTICE:

An investigative proceeding will be held pursuant to the provisions of N.Y. Pub. Health Law, Section 230 (7) (McKinney Supp. 1988). The proceedings will be conducted before a committee on professional conduct on the 26th of May, 1988 at 10:00 in the forenoon of that day at the Ramada Renaissance Hotel, 4243 Genesee Street, Cheektowaga, New York 14225, and at such other adjourned dates, times and places as the committee may direct.

The sole issues to be addressed at the investigative proceeding are whether the committee, based on the information adduced at the hearing has reason to believe that you may be impaired by mental disability and, therefore, whether it should issue an order directing that you submit to a complete psychiatric examination.

A stenographic record of the proceeding will be made. You may appear in person at the proceeding and may be represented by counsel.

The proceeding will proceed whether or not you appear. Please note that requests for adjournments must be made in

writing to the Chairperson of the Committee, c/o Office of Professional Medical Conduct, Empire State Plaza, Corning Tower Building, 25th Floor, Albany, New York 12237 and by telephone (518-474-8357), upon notice to the attorney for the Department of Health whose name appears below, and at least five days prior to the scheduled date. Claims of court engagement will require detailed Affidavits of Actual Engagement. Claims of illness will require medical documentation.

At the conclusion of the proceeding and after review of the information presented, the committee will determine whether or not to direct that you submit to a medical or psychiatric examination, if so ordered.

The result of said examination, if ordered, will be made available to you, the committee and the Office of Professional Medical Conduct. In addition, the results will be admissible into evidence in the event a subsequent disciplinary hearing is instituted regarding this matter. You may obtain a physician to conduct an examination, the results of which shall be provided to the committee and the Office of Professional Medical Conduct.

SINCE THIS PROCEEDING CONCERNS YOUR PRACTICE OF MEDICINE IN NEW YORK STATE, YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATED: Albany, New York
April 6, 1988

PETER D. VAN BUREN
Deputy Counsel
Bureau of Professional
Medical Conduct

Inquiries should be directed to:

PAUL R. WHITE
Associate Counsel, Division of Legal Affairs
Professional Medical Conduct Unit, Corning Tower Building - Room 2429, Empire State Plaza,
Albany, New York 12237
Telephone Number: (518) 473-7772

CONSTITUTIONAL PROVISIONS, STATUTES AND RULES INVOLVED

U.S. Constitution, Article IV, section 3, provides:

The Senators and Representatives before mentioned, and the members of the several State Legislatures, and all executives and judicial officers, both of the United States and of the several States, shall be bound by oath or affirmation to support this Constitution.

U.S. Constitution, Amendment XIV, section 1, provides:

... No state shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States, nor shall any state deprive any person of life, liberty or property without due process of law, nor deny to any person within its jurisdiction the equal protection of the laws.

18 U.S.C. 241. Conspiracy against rights of citizens

If two or more persons conspire to injure, oppress, threaten, or intimidate any citizen in the free exercise or enjoyment of any right or privilege secured to him by the Constitution or laws of the United States, or because of his having so exercised the same; or

If two or more persons go in disguise on the highway, or on the premises of another, with intent to prevent or hinder his free exercise or enjoyment of any right or privilege so secured -

They shall be fined not more that $ 10,000 or imprisoned not more that ten years, or both; and if death shall result, they shall be subject to imprisonment for a term of years or for life.

18 U.S.C. 242. Deprivation of rights under color of law.

Whosoever, under color of any law, statute, ordinance, regulation, or custom, willfully subjects any inhabitant of any State, Territory, or District to the deprivation of any rights, privileges, or immunities secured or protected by the Constitution or laws of the United States, or to different punishments, pains, or penalties, on account of such inhabitant being an alien, or by

reason of his color, or race, than any prescribed for the punishment of citizens, shall be fined not more that $ 1,000 or imprisoned not more that one year, or both; and if death results shall be subject to imprisonment for any term of years or for life.

28 U.S.C. 1343. Civil rights and elective franchise

(a) The district court shall have original jurisdiction of any civil action authorized by law to be commenced by any person:

(1) To recover damages for injury to his person or property, or because of deprivation of any right or privilege of a citizen of the United States, by any act done in furtherance of any conspiracy mentioned in section 1985 of Title 42;

(2) To recover damages from any person who fails to prevent or to aid in preventing any wrongs mentioned in section 1985 of Title 42 which he had knowledge were about to occur and power to prevent;

(3) To redress the deprivation, under color of any State law, statute, ordinance, regulation, custom or usage, of any right, privilege or immunity secured by the Constitution of the United States or by any Act of Congress for equal rights of citizens or of all persons within the jurisdiction of the United States;

(4) To recover damages or to secure equitable or other relief under any Act of Congress providing for the protection of civil rights, including the right to vote.

42 U.S.C. 1985

If two or more persons in any State or Territory conspire or go in disguise on the highway or on the premises of another, for the purpose of depriving, either directly or indirectly, any person or class of persons of the equal protection of the laws, or of equal privileges and immunities under the laws; or for the purpose of preventing or hindering the constituted authorities of any State or Territory from giving or securing to all persons within such State or Territory the equal protection of the laws;

or if two or more persons conspire to prevent by force, intimidation, or threat, any citizen who is lawfully entitled to vote, from giving his support or advocacy in a legal manner, toward or in favor of the election of any lawfully qualified person as an elector for President or Vice President, or as a Member of Congress of the United States;

or to injure any citizen in person or property on account of such support or advocacy; in any case of conspiracy set forth in this section, if one or more persons engaged therein do, or cause to be done, any act in furtherance of the object of such conspiracy, whereby another is injured in his person or property, or deprived of having and exercising any right or privilege of a citizen of the United States, the party so injured or deprived may have an action for the recovery of damages, occasioned by such injury or deprivation, against any one or more of the conspirators.

42 U.S.C. 1986

Every person who, having knowledge that any of the wrongs conspired to be done, and mentioned in section 1985 of this title, are about to be committed, and having power to prevent or aid in preventing the commission of the same, neglects or refuses so to do, if such wrongful act be committed, shall be liable to the party injured, or his legal representatives, for all damages caused by such wrongful act, which such person by reasonable diligence could have prevented; and such damages may be recovered in an action on the case; and any number of persons guilty of such wrongful neglect or refusal may be joined as defendants in the action.

New York State statutes, rules

N.Y. Educ. Law section 6509(2) (McKinney 1985), relates to professional misconduct and prohibits:

Practicing the profession fraudulently, beyond its authorized scope, with gross incompetence, with gross negligence on a particular occasion or negligence or incompetence on more than one occasion.

N.Y. Educ. Law section 6509(9) (McKinney 1985) provides:

Committing unprofessional conduct as defined by the board of regents in its rules or by the commissioner in regulations approved by the board of regents.

8 NYCRR 29.1(a)(8) (1984) of the Rules of the Board of Regents which reads as follows:

(8) revealing of personally identifiable facts, data or information obtained in a professional capacity without the prior consent of the patient or client, except as authorized or required by law.

8 NYCRR 29.2(a)(1) (1987) of the Rules of the Board of Regents which reads as follows:

(1) abandoning or neglecting a patient or client under and in need of immediate professional care, without making reasonable arrangements for the continuation of such care, or abandoning a professional employment by a group practice, hospital, clinic or other health care facility, without reasonable notice and under circumstances which seriously impair the deliver of professional care to patients or clients.

8 NYCRR 29.2(a)(2)(1987) of the Rules of the Board of Regents which reads as follows:

(2) willfully harassing, abusing or intimidating a patient either physically or verbally.

8 NYCRR 29.2(a)(3)(1987) of the Rules of the Board of Regents which reads as follows:

(3) failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient.